

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 215

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>MONTGOMERY</b>		MARYLAND		STATE <b>New York</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Bethesda, (Rural)</b>		LENGTH OF STAY (in this place) <b>18 days</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Bronx</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>				STREET ADDRESS (If rural, give location) <b>3454 Fenton Street</b>			
3. NAME OF DECEASED: (First) <b>JEROME</b>		(Middle) <b>BERNARD</b>		(Last) <b>AEOLIAN</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>17</b> (Year) <b>1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>8 Sept. 1930</b>		9. AGE last birthday: <b>25</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>USMC</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>USMC</b>		11. BIRTHPLACE (State or foreign country): <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME: <b>LEON AEOLIAN</b>				14. MOTHER'S MAIDEN NAME: <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>yes</b>		16. SOCIAL SECURITY No.: <b>Unknown</b>		17. INFORMANT & ADDRESS: <b>New York City, N.Y. (Sister) Mrs. Paula KRITZ, 1803 Riverside Dr.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						22 days	
Immediate cause (a) <b>Cerebral hemorrhage &amp; laceration</b> DUE TO Antecedent cause(s) (b) <b>Communicated fracture of skull (depressed)</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <b>Street</b>		21c. (City or town) <b>Washington D.C.</b> (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2-24-56 12:40 A.M.</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Driver failed which struck buttrest of car</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <b>Frank J. Brothman</b>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <b>3-18-56</b>	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>3-20-56</b>		NAME OF CEMETERY OR CREMATORY <b>Mount Carmel Cemetery</b>		LOCATION (City, town, or county) <b>Brooklyn, New York</b> (State)	
DATE REC'D BY LOCAL REG. <b>18 March 1956</b>		REGISTRAR'S SIGNATURE <b>Mary E. Parnell</b>		24. FUNERAL DIRECTOR <b>Bethesda, Md. R.A. PUMPHREY, 7557 Wisconsin Ave.,</b>			

02962

3022

BUREAU V. S.

MAR 21 1936

RECEIVED

RECEIVED  
MAR 21 1936  
BUREAU V. S.

UNKNOWN

NEW YORK

Japanese, (male)

10 days

1935

U.S. Naval Hospital, Bethesda, Md. 1001 Hunter Street

UNKNOWN

UNKNOWN

UNKNOWN

MARCH 17

1935

Male

White

Single

6 Sept. 1935

1935

UNKNOWN

UNKNOWN

NEW YORK

1935

UNKNOWN

UNKNOWN

Korea

UNKNOWN

(sister) Mr. Paul Hill, 1003 Riverside Dr.

NEW YORK CITY, N.Y.

3023

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>St. Mary's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lexington Park</b> <b>18X-2</b>	
f. STREET ADDRESS <b>21 Levin Drive</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Belle</b> Last <b>ALLEN</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 Sept. 1926</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Ernest WARREN</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Lexington Park, Md.</b> <b>(Husband) William E. ALLEN, 21 Levin Drive,</b>			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid Hemorrhage</b> <b>330x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>26 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>16 March</b> , 19 <b>56</b> , to <b>17 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>17 March</b> , 19 <b>56</b> , and that death occurred at <b>1835</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert W. Mackie</b>		ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b>	
DATE SIGNED <b>3-19-56</b>			
PHYSICIAN'S NAME (Type) <b>Robert W. MACKIE, CDR, MC, USN</b>		<b>U.S. Naval Hospital, Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>22 March 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Providence</b>		22d. LOCATION (City, town, or county) (State) <b>Liberty Clay Co. Missouri</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bary E. Tarselly</b>	
ADDRESS <b>R.A. PUMPHREY FUNERAL HOME</b> <b>7557 WISCONSIN Ave., Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 7

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02964

No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>ind</u>	COUNTY <u>Montg</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9902 Cedar Lane</u>		STREET ADDRESS (If rural, give location) <u>9902 Cedar Lane</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Bradford</u> (Last) <u>Allyn Jr.</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>15</u> (Year) <u>1956</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Aug. 26, 1946</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	9. AGE last birthday: <u>9</u> yrs. <u>8</u> Months <u>19</u> Days
11. BIRTHPLACE (State or foreign country): <u>Boston, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John B. Allyn, Sr.</u>		14. MOTHER'S MAIDEN NAME: <u>Joanne Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>--</u>		16. SOCIAL SECURITY No.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>John B. Allyn, Sr. Father, 9902 Cedar Lane, Bethesda, Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Intra-aortic aortic hemorrhage (Cardiac Tamponade)</u>			<u>See Remarks</u>
DUE TO			
Antecedent cause(s) (b) <u>Rupture 1st part Aorta</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Idiopathic Median Necrosis Aorta</u>			<u>? years</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Original Heart disease - patent ductus</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>3-16-56</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify) <u>Burial-transit</u>	DATE THEREOF <u>3-18-56</u>	NAME OF CEMETERY OR CREMATORY <u>Holliston</u>	LOCATION (City, town, or county) (State) <u>Middlesex Co. Mass.</u>
DATE REC'D BY LOCAL REG. <u>3-16-56</u>	REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Md.</u>	

BUREAU V. B.

MAR 19 1956

RECEIVED

3025

02965

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 214

## 1. PLACE OF DEATH:

COUNTY Montgomery MARYLANDCITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Silver Spring LENGTH OF STAY (in this place)HOSPITAL OR INSTITUTION OR STREET ADDRESS 8915 Georgia Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE md COUNTY MontgCITY (If outside corporate limits write RURAL and give nearest town) TOWN Silver Spring 56STREET ADDRESS (If rural, give location) 8915 Georgia Ave3. NAME OF DECEASED: (Type or Print) Fredrick Theodore Arends

(First)

(Middle)

(Last)

4. DATE OF DEATH Mar 4 1956

(Month)

(Day)

(Year)

5. SEX: MALE6. COLOR OR RACE: WHITE7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE8. DATE OF BIRTH: SEPT. 24, 19389. AGE last birthday: 17 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Student at Montgomery Blair High

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): WASHINGTON, DC.12. CITIZEN OF WHAT COUNTRY? U.S.A.13. FATHER'S NAME: THEODORE GEORGE ARENDS14. MOTHER'S MAIDEN NAME: LOUISE VOGEL15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)16. SOCIAL SECURITY No.: NONE17. INFORMANT & ADDRESS: THEODORE G. ARENDS, 8915 GA.AVE., SS., MD.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause Asphyxia due to lack of oxygen

(a) DUE TO

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH Ind dead

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Home21c. (City or town) (County) Silver Spring Montg md21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3-4-56 8 A M.21e. INJURY OCCURRED While at work ☐ Not while at work ☒21f. HOW DID INJURY OCCUR? Found dead with illuminating gas tube in mouth22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined cause ☐.SIGNATURE Frank J. BruchartM. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☒DATE SIGNED 3-4-5623. BURIAL, CREMATION, REMOVAL (Specify): BURIALDATE THEREOF MARCH 6, 1956NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERYLOCATION (City, town, or county) (State) SUITLAND, PR. GEO. CO. MDDATE REC'D BY LOCAL REG. 3-6-56REGISTRAR'S SIGNATURE Frances Potter24. FUNERAL DIRECTOR Waxmox E. PumphreyADDRESS SILVER SPRING, MD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

1956 9 MAR

RECEIVED

## 3026 CERTIFICATE OF DEATH

02966

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>12 hrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery Co. General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Infant Boy Arnold</b>		4. DATE OF DEATH <b>Month Day Year</b> <b>March 2 19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1956</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newborn</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	9. AGE (In years last birthday) yrs. <b>12</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Billy Richard Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Mable Lucinda Buner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - - - -</b>	
17. INFORMANT <b>Mother</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>761.0</b> IMMEDIATE CAUSE (a) <b>Atalactasis</b> DUE TO <b>Baby delivered by section. Placenta previa</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Due to</b> <b>right 5 lbs more weight, but healthy</b> (b) <b>might 5 lbs more weight, but healthy</b> (c) <b>might 5 lbs more weight, but healthy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5:30 am 3/2/56</b> to <b>8:50 pm 3/2/56</b> , that I last saw the deceased alive on <b>3/2/56</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. W. Bird</b>		ADDRESS (Street, city or town, state) <b>Sandy Pt. Md.</b> DATE SIGNED <b>3/2/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Savage</b>		22d. LOCATION (City, town, or county) (State) <b>Howard Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE 3/6-56</b>		24b. REGISTRAR'S SIGNATURE <b>Katherine B. Fowler</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2073223402





3027

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>7 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u>		d. STREET ADDRESS <u>13X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery County General Hospital, Inc.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Bailey</u> Last <u>Bailey</u>				4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 14, 1887</u>	
9. AGE (In years last birthday) <u>72 yrs.</u>		IF UNDER 1 YEAR Months <u>72</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Charlie Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Nell Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>916.0</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO <u>916.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Second degree burns of head + arms?</u> DUE TO <u>6 hrs</u> (c) <u>6 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <u>916.0</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Impulse from 2nd floor of burning home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-20-56</u> p. m. <u>3-20-56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>		20f. (City or town) (County) (State) <u>Cooksville Howard Co</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart, M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5-15-56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Hopkins Medical School</u>		22d. LOCATION (City, town, or county) (State) <u>Cooksville Howard Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Beatrice B. Lawler</u>				24a. REC'D BY REGISTRAR <u>Beatrice B. Lawler</u>		24b. REGISTRAR'S SIGNATURE <u>Beatrice B. Lawler</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

MAY 15 1956

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: \_\_\_\_\_  
2. SEX: \_\_\_\_\_  
3. AGE: \_\_\_\_\_  
4. DATE OF BIRTH: \_\_\_\_\_  
5. PLACE OF BIRTH: \_\_\_\_\_  
6. OCCUPATION: \_\_\_\_\_  
7. CAUSE OF DEATH: \_\_\_\_\_  
8. MANNER OF DEATH: \_\_\_\_\_  
9. SIGNATURE OF EXAMINER: \_\_\_\_\_  
10. DATE OF EXAMINATION: \_\_\_\_\_

3028

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>				c. LENGTH OF STAY IN 1b <b>2 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>				47X-3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>				d. STREET ADDRESS <b>2917 Bellview Terrace, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Sarge</b> Last <b>BALL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 6 1869</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Commercial</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John A. BALL</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth DIRD</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>C.R. BALL, Capt.MC,USN (Son)</b>		Address <b>2-D</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastro-intestinal Hemorrhage</b> <b>578X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cause unknown</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of the prostate</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>23 March</b> , 19 <b>56</b> , to <b>25 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>25 March</b> , 19 <b>56</b> , and that death occurred at <b>7:20A</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Gerald I. Plitman</b>		M.D. <b>U.S. NAVAL HOSPITAL, BETHESDA, MD.</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>3-26-56</b>	
PHYSICIAN'S NAME (Type) <b>Gerald I. PLITMAN, LT, MC, USN</b>		U.S. NAVAL HOSPITAL, BETHESDA, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3-27-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b> <b>7557 Wisconsin Ave.,</b>		24a. REC'D BY REGISTRAR DATE <b>3-26-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

NAME OF DECEASED (Print Name)		SEX (Male or Female)		AGE (Years)	
DATE OF BIRTH (Month, Day, Year)		PLACE OF BIRTH (City, State, Country)		OCCUPATION (If any)	
DATE OF DEATH (Month, Day, Year)		PLACE OF DEATH (City, State, Country)		CAUSE OF DEATH (If known)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)		SIGNATURE OF PHYSICIAN (If known)	
SIGNATURE OF CLERK (If known)		SIGNATURE OF REGISTRAR (If known)		SIGNATURE OF JUDGE (If known)	

RECEIVED  
 MAR 29 1956  
 BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02968

2985

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>TAKOMA PARK</i>		c. LENGTH OF STAY IN lb <i>35 Years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium &amp; Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Hayward</i> Last <i>Beall</i>		4. DATE OF DEATH Month <i>3</i> Day <i>-25-</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-11-20</i>
9. AGE (In years last birthday) <i>35</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Equipment Specialist</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Naval Gun Factory</i>	
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Hayward Beall</i>		14. MOTHER'S MAIDEN NAME <i>Cecilia Chisolm</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i> (If yes, give war or dates of service) <i>Army</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Wife - Mrs Bettie Beall</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage</i> DUE TO <i>330X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rupture Aneurysm Basilar Artery</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>24 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>NO</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 1</i> 1952, to <i>3-25-</i> 1956, that I last saw the deceased alive on <i>3-25-</i> 1956, and that death occurred at <i>8:40 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8005 Woodbury Drive</i> DATE SIGNED	
ACTUAL SIGNATURE <i>N.C. Shoemaker</i>		PHYSICIAN'S NAME (Type) <i>N.C. SHOEMAKER, M.D.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/28/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Arlington Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geiers Funeral Home</i>		ADDRESS <i>3608-14th St. N.W.</i>	
24a. REC'D BY REGISTRAR <i>3/15/56</i>		24b. REGISTRAR'S SIGNATURE <i>John A. Dock</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65 years</i>		4. DATE OF DEATH <i>March 27, 1956</i>	
5. PLACE OF DEATH <i>Home</i>		6. CITY <i>Boston</i>		7. COUNTY <i>Suffolk</i>		8. STATE <i>Massachusetts</i>	
9. OCCUPATION <i>Retired</i>		10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>	
13. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		14. SIGNATURE OF DECEASED <i>John J. Smith</i>		15. SIGNATURE OF WITNESS <i>John A. Smith</i>		16. SIGNATURE OF WITNESS <i>John A. Smith</i>	
17. SIGNATURE OF WITNESS <i>John A. Smith</i>		18. SIGNATURE OF WITNESS <i>John A. Smith</i>		19. SIGNATURE OF WITNESS <i>John A. Smith</i>		20. SIGNATURE OF WITNESS <i>John A. Smith</i>	
21. SIGNATURE OF WITNESS <i>John A. Smith</i>		22. SIGNATURE OF WITNESS <i>John A. Smith</i>		23. SIGNATURE OF WITNESS <i>John A. Smith</i>		24. SIGNATURE OF WITNESS <i>John A. Smith</i>	
25. SIGNATURE OF WITNESS <i>John A. Smith</i>		26. SIGNATURE OF WITNESS <i>John A. Smith</i>		27. SIGNATURE OF WITNESS <i>John A. Smith</i>		28. SIGNATURE OF WITNESS <i>John A. Smith</i>	
29. SIGNATURE OF WITNESS <i>John A. Smith</i>		30. SIGNATURE OF WITNESS <i>John A. Smith</i>		31. SIGNATURE OF WITNESS <i>John A. Smith</i>		32. SIGNATURE OF WITNESS <i>John A. Smith</i>	
33. SIGNATURE OF WITNESS <i>John A. Smith</i>		34. SIGNATURE OF WITNESS <i>John A. Smith</i>		35. SIGNATURE OF WITNESS <i>John A. Smith</i>		36. SIGNATURE OF WITNESS <i>John A. Smith</i>	
37. SIGNATURE OF WITNESS <i>John A. Smith</i>		38. SIGNATURE OF WITNESS <i>John A. Smith</i>		39. SIGNATURE OF WITNESS <i>John A. Smith</i>		40. SIGNATURE OF WITNESS <i>John A. Smith</i>	
41. SIGNATURE OF WITNESS <i>John A. Smith</i>		42. SIGNATURE OF WITNESS <i>John A. Smith</i>		43. SIGNATURE OF WITNESS <i>John A. Smith</i>		44. SIGNATURE OF WITNESS <i>John A. Smith</i>	
45. SIGNATURE OF WITNESS <i>John A. Smith</i>		46. SIGNATURE OF WITNESS <i>John A. Smith</i>		47. SIGNATURE OF WITNESS <i>John A. Smith</i>		48. SIGNATURE OF WITNESS <i>John A. Smith</i>	
49. SIGNATURE OF WITNESS <i>John A. Smith</i>		50. SIGNATURE OF WITNESS <i>John A. Smith</i>		51. SIGNATURE OF WITNESS <i>John A. Smith</i>		52. SIGNATURE OF WITNESS <i>John A. Smith</i>	
53. SIGNATURE OF WITNESS <i>John A. Smith</i>		54. SIGNATURE OF WITNESS <i>John A. Smith</i>		55. SIGNATURE OF WITNESS <i>John A. Smith</i>		56. SIGNATURE OF WITNESS <i>John A. Smith</i>	
57. SIGNATURE OF WITNESS <i>John A. Smith</i>		58. SIGNATURE OF WITNESS <i>John A. Smith</i>		59. SIGNATURE OF WITNESS <i>John A. Smith</i>		60. SIGNATURE OF WITNESS <i>John A. Smith</i>	
61. SIGNATURE OF WITNESS <i>John A. Smith</i>		62. SIGNATURE OF WITNESS <i>John A. Smith</i>		63. SIGNATURE OF WITNESS <i>John A. Smith</i>		64. SIGNATURE OF WITNESS <i>John A. Smith</i>	
65. SIGNATURE OF WITNESS <i>John A. Smith</i>		66. SIGNATURE OF WITNESS <i>John A. Smith</i>		67. SIGNATURE OF WITNESS <i>John A. Smith</i>		68. SIGNATURE OF WITNESS <i>John A. Smith</i>	
69. SIGNATURE OF WITNESS <i>John A. Smith</i>		70. SIGNATURE OF WITNESS <i>John A. Smith</i>		71. SIGNATURE OF WITNESS <i>John A. Smith</i>		72. SIGNATURE OF WITNESS <i>John A. Smith</i>	
73. SIGNATURE OF WITNESS <i>John A. Smith</i>		74. SIGNATURE OF WITNESS <i>John A. Smith</i>		75. SIGNATURE OF WITNESS <i>John A. Smith</i>		76. SIGNATURE OF WITNESS <i>John A. Smith</i>	
77. SIGNATURE OF WITNESS <i>John A. Smith</i>		78. SIGNATURE OF WITNESS <i>John A. Smith</i>		79. SIGNATURE OF WITNESS <i>John A. Smith</i>		80. SIGNATURE OF WITNESS <i>John A. Smith</i>	
81. SIGNATURE OF WITNESS <i>John A. Smith</i>		82. SIGNATURE OF WITNESS <i>John A. Smith</i>		83. SIGNATURE OF WITNESS <i>John A. Smith</i>		84. SIGNATURE OF WITNESS <i>John A. Smith</i>	
85. SIGNATURE OF WITNESS <i>John A. Smith</i>		86. SIGNATURE OF WITNESS <i>John A. Smith</i>		87. SIGNATURE OF WITNESS <i>John A. Smith</i>		88. SIGNATURE OF WITNESS <i>John A. Smith</i>	
89. SIGNATURE OF WITNESS <i>John A. Smith</i>		90. SIGNATURE OF WITNESS <i>John A. Smith</i>		91. SIGNATURE OF WITNESS <i>John A. Smith</i>		92. SIGNATURE OF WITNESS <i>John A. Smith</i>	
93. SIGNATURE OF WITNESS <i>John A. Smith</i>		94. SIGNATURE OF WITNESS <i>John A. Smith</i>		95. SIGNATURE OF WITNESS <i>John A. Smith</i>		96. SIGNATURE OF WITNESS <i>John A. Smith</i>	
97. SIGNATURE OF WITNESS <i>John A. Smith</i>		98. SIGNATURE OF WITNESS <i>John A. Smith</i>		99. SIGNATURE OF WITNESS <i>John A. Smith</i>		100. SIGNATURE OF WITNESS <i>John A. Smith</i>	

BUREAU V. S.

MAR 27 1956

RECEIVED



3029

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Ernest</i> Middle <i>C</i> Last <i>Beck</i>		4. DATE OF DEATH Month <i>March</i> Day <i>9<sup>th</sup></i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 8, 1868</i>
9. AGE (In years last birthday) <i>87</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Food Products Sales Agent</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BALTIMORE, MARYLAND</i>	
11. BIRTHPLACE (State or foreign country) <i>215A</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>George H. Beck</i>		14. MOTHER'S MAIDEN NAME <i>Ida Bollman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mr. DeLebay</i>		Address <i>115 W. Saratoga St</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> (c) <i>Extensive 2° Burns of Skin</i>		INTERVAL BETWEEN ONSET AND DEATH <i>48 hrs</i> <i>20 years</i> <i>36 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Adenocarcinoma of Prostate</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Feb 2 1956</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Feb 2</i> , 19 <i>56</i> , to <i>March 8</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>March 8</i> , 19 <i>56</i> , and that death occurred at <i>3:40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. McCann</i>		ADDRESS (Street, city or town, state) <i>809 Viers Mill Rd. Rockville Md.</i>	
PHYSICIAN'S NAME (Type) <i>Rockville Md.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/12/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Landon Park Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook, Inc.</i>		ADDRESS <i>1217 St. Paul St. Baltimore</i>	
24a. REC'D BY REGISTRAR <i>Mar 12 1956</i>		24b. REGISTRAR'S SIGNATURE <i>May E. Linnell</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION		11. SERVICE		12. GRADE		13. PAY		14. DUTY		15. STATUS		16. GRADE		17. PAY		18. DUTY		19. STATUS		20. GRADE		21. PAY		22. DUTY		23. STATUS		24. GRADE		25. PAY		26. DUTY		27. STATUS		28. GRADE		29. PAY		30. DUTY		31. STATUS		32. GRADE		33. PAY		34. DUTY		35. STATUS		36. GRADE		37. PAY		38. DUTY		39. STATUS		40. GRADE		41. PAY		42. DUTY		43. STATUS		44. GRADE		45. PAY		46. DUTY		47. STATUS		48. GRADE		49. PAY		50. DUTY		51. STATUS		52. GRADE		53. PAY		54. DUTY		55. STATUS		56. GRADE		57. PAY		58. DUTY		59. STATUS		60. GRADE		61. PAY		62. DUTY		63. STATUS		64. GRADE		65. PAY		66. DUTY		67. STATUS		68. GRADE		69. PAY		70. DUTY		71. STATUS		72. GRADE		73. PAY		74. DUTY		75. STATUS		76. GRADE		77. PAY		78. DUTY		79. STATUS		80. GRADE		81. PAY		82. DUTY		83. STATUS		84. GRADE		85. PAY		86. DUTY		87. STATUS		88. GRADE		89. PAY		90. DUTY		91. STATUS		92. GRADE		93. PAY		94. DUTY		95. STATUS		96. GRADE		97. PAY		98. DUTY		99. STATUS		100. GRADE		101. PAY		102. DUTY		103. STATUS		104. GRADE		105. PAY		106. DUTY		107. STATUS		108. GRADE		109. PAY		110. DUTY		111. STATUS		112. GRADE		113. PAY		114. DUTY		115. STATUS		116. GRADE		117. PAY		118. DUTY		119. STATUS		120. GRADE		121. PAY		122. DUTY		123. STATUS		124. GRADE		125. PAY		126. DUTY		127. STATUS		128. GRADE		129. PAY		130. DUTY		131. STATUS		132. GRADE		133. PAY		134. DUTY		135. STATUS		136. GRADE		137. PAY		138. DUTY		139. STATUS		140. GRADE		141. PAY		142. DUTY		143. STATUS		144. GRADE		145. PAY		146. DUTY		147. STATUS		148. GRADE		149. PAY		150. DUTY		151. STATUS		152. GRADE		153. PAY		154. DUTY		155. STATUS		156. GRADE		157. PAY		158. DUTY		159. STATUS		160. GRADE		161. PAY		162. DUTY		163. STATUS		164. GRADE		165. PAY		166. DUTY		167. STATUS		168. GRADE		169. PAY		170. DUTY		171. STATUS		172. GRADE		173. PAY		174. DUTY		175. STATUS		176. GRADE		177. PAY		178. DUTY		179. STATUS		180. GRADE		181. PAY		182. DUTY		183. STATUS		184. GRADE		185. PAY		186. DUTY		187. STATUS		188. GRADE		189. PAY		190. DUTY		191. STATUS		192. GRADE		193. PAY		194. DUTY		195. STATUS		196. GRADE		197. PAY		198. DUTY		199. STATUS		200. GRADE		201. PAY		202. DUTY		203. STATUS		204. GRADE		205. PAY		206. DUTY		207. STATUS		208. GRADE		209. PAY		210. DUTY		211. STATUS		212. GRADE		213. PAY		214. DUTY		215. STATUS		216. GRADE		217. PAY		218. DUTY		219. STATUS		220. GRADE		221. PAY		222. DUTY		223. STATUS		224. GRADE		225. PAY		226. DUTY		227. STATUS		228. GRADE		229. PAY		230. DUTY		231. STATUS		232. GRADE		233. PAY		234. DUTY		235. STATUS		236. GRADE		237. PAY		238. DUTY		239. STATUS		240. GRADE		241. PAY		242. DUTY		243. STATUS		244. GRADE		245. PAY		246. DUTY		247. STATUS		248. GRADE		249. PAY		250. DUTY		251. STATUS		252. GRADE		253. PAY		254. DUTY		255. STATUS		256. GRADE		257. PAY		258. DUTY		259. STATUS		260. GRADE		261. PAY		262. DUTY		263. STATUS		264. GRADE		265. PAY		266. DUTY		267. STATUS		268. GRADE		269. PAY		270. DUTY		271. STATUS		272. GRADE		273. PAY		274. DUTY		275. STATUS		276. GRADE		277. PAY		278. DUTY		279. STATUS		280. GRADE		281. PAY		282. DUTY		283. STATUS		284. GRADE		285. PAY		286. DUTY		287. STATUS		288. GRADE		289. PAY		290. DUTY		291. STATUS		292. GRADE		293. PAY		294. DUTY		295. STATUS		296. GRADE		297. PAY		298. DUTY		299. STATUS		300. GRADE		301. PAY		302. DUTY		303. STATUS		304. GRADE		305. PAY		306. DUTY		307. STATUS		308. GRADE		309. PAY		310. DUTY		311. STATUS		312. GRADE		313. PAY		314. DUTY		315. STATUS		316. GRADE		317. PAY		318. DUTY		319. STATUS		320. GRADE		321. PAY		322. DUTY		323. STATUS		324. GRADE		325. PAY		326. DUTY		327. STATUS		328. GRADE		329. PAY		330. DUTY		331. STATUS		332. GRADE		333. PAY		334. DUTY		335. STATUS		336. GRADE		337. PAY		338. DUTY		339. STATUS		340. GRADE		341. PAY		342. DUTY		343. STATUS		344. GRADE		345. PAY		346. DUTY		347. STATUS		348. GRADE		349. PAY		350. DUTY		351. STATUS		352. GRADE		353. PAY		354. DUTY		355. STATUS		356. GRADE		357. PAY		358. DUTY		359. STATUS		360. GRADE		361. PAY		362. DUTY		363. STATUS		364. GRADE		365. PAY		366. DUTY		367. STATUS		368. GRADE		369. PAY		370. DUTY		371. STATUS		372. GRADE		373. PAY		374. DUTY		375. STATUS		376. GRADE		377. PAY		378. DUTY		379. STATUS		380. GRADE		381. PAY		382. DUTY		383. STATUS		384. GRADE		385. PAY		386. DUTY		387. STATUS		388. GRADE		389. PAY		390. DUTY		391. STATUS		392. GRADE		393. PAY		394. DUTY		395. STATUS		396. GRADE		397. PAY		398. DUTY		399. STATUS		400. GRADE		401. PAY		402. DUTY		403. STATUS		404. GRADE		405. PAY		406. DUTY		407. STATUS		408. GRADE		409. PAY		410. DUTY		411. STATUS		412. GRADE		413. PAY		414. DUTY		415. STATUS		416. GRADE		417. PAY		418. DUTY		419. STATUS		420. GRADE		421. PAY		422. DUTY		423. STATUS		424. GRADE		425. PAY		426. DUTY		427. STATUS		428. GRADE		429. PAY		430. DUTY		431. STATUS		432. GRADE		433. PAY		434. DUTY		435. STATUS		436. GRADE		437. PAY		438. DUTY		439. STATUS		440. GRADE		441. PAY		442. DUTY		443. STATUS		444. GRADE		445. PAY		446. DUTY		447. STATUS		448. GRADE		449. PAY		450. DUTY		451. STATUS		452. GRADE		453. PAY		454. DUTY		455. STATUS		456. GRADE		457. PAY		458. DUTY		459. STATUS		460. GRADE		461. PAY		462. DUTY		463. STATUS		464. GRADE		465. PAY		466. DUTY		467. STATUS		468. GRADE		469. PAY		470. DUTY		471. STATUS		472. GRADE		473. PAY		474. DUTY		475. STATUS		476. GRADE		477. PAY		478. DUTY		479. STATUS		480. GRADE		481. PAY		482. DUTY		483. STATUS		484. GRADE		485. PAY		486. DUTY		487. STATUS		488. GRADE		489. PAY		490. DUTY		491. STATUS		492. GRADE		493. PAY		494. DUTY		495. STATUS		496. GRADE		497. PAY		498. DUTY		499. STATUS		500. GRADE		501. PAY		502. DUTY		503. STATUS		504. GRADE		505. PAY		506. DUTY		507. STATUS		508. GRADE		509. PAY		510. DUTY		511. STATUS		512. GRADE		513. PAY		514. DUTY		515. STATUS		516. GRADE		517. PAY		518. DUTY		519. STATUS		520. GRADE		521. PAY		522. DUTY		523. STATUS		524. GRADE		525. PAY		526. DUTY		527. STATUS		528. GRADE		529. PAY		530. DUTY		531. STATUS		532. GRADE		533. PAY		534. DUTY		535. STATUS		536. GRADE		537. PAY		538. DUTY		539. STATUS		540. GRADE		541. PAY		542. DUTY		543. STATUS		544. GRADE		545. PAY		546. DUTY		547. STATUS		548. GRADE		549. PAY		550. DUTY		551. STATUS		552. GRADE		553. PAY		554. DUTY		555. STATUS		556. GRADE		557. PAY		558. DUTY		559. STATUS		560. GRADE		561. PAY		562. DUTY		563. STATUS		564. GRADE		565. PAY		566. DUTY		567. STATUS		568. GRADE		569. PAY		570. DUTY		571. STATUS		572. GRADE		573. PAY		574. DUTY		575. STATUS		576. GRADE		577. PAY		578. DUTY		579. STATUS		580. GRADE		581. PAY		582. DUTY		583. STATUS		584. GRADE		585. PAY		586. DUTY		587. STATUS		588. GRADE		589. PAY		590. DUTY		591. STATUS		592. GRADE		593. PAY		594. DUTY		595. STATUS		596. GRADE		597. PAY		598. DUTY		599. STATUS		600. GRADE		601. PAY		602. DUTY		603. STATUS		604. GRADE		605. PAY		606. DUTY		607. STATUS		608. GRADE		609. PAY		610. DUTY		611. STATUS		612. GRADE		613. PAY		614. DUTY		615. STATUS		616. GRADE		617. PAY		618. DUTY		619. STATUS		620. GRADE		621. PAY		622. DUTY		623. STATUS		624. GRADE		625. PAY		626. DUTY		627. STATUS		628. GRADE		629. PAY		630. DUTY		631. STATUS		632. GRADE		633. PAY		634. DUTY		635. STATUS		636. GRADE		637. PAY		638. DUTY		639. STATUS		640. GRADE		641. PAY		642. DUTY		643. STATUS		644. GRADE		645. PAY		646. DUTY		647. STATUS		648. GRADE		649. PAY		650. DUTY		651. STATUS		652. GRADE		653. PAY		654. DUTY		655. STATUS		656. GRADE		657. PAY		658. DUTY		659. STATUS		660. GRADE		661. PAY		662. DUTY		663. STATUS		664. GRADE		665. PAY		666. DUTY		667. STATUS		668. GRADE		669. PAY		670. DUTY		671. STATUS		672. GRADE		673. PAY		674. DUTY		675. STATUS		676. GRADE		677. PAY		678. DUTY		679. STATUS		680. GRADE		681. PAY		682. DUTY		683. STATUS		684. GRADE		685. PAY		686. DUTY		687. STATUS		688. GRADE		689. PAY		690. DUTY		691. STATUS		692. GRADE		693. PAY		694. DUTY		695. STATUS		696. GRADE		697. PAY		698. DUTY		699. STATUS		700. GRADE		701. PAY		702. DUTY		703. STATUS		704. GRADE		705. PAY		706. DUTY		707. STATUS		708. GRADE		709. PAY		710. DUTY		711. STATUS		712. GRADE		713. PAY		714. DUTY		715. STATUS		716. GRADE		717. PAY		718. DUTY		719. STATUS		720. GRADE		721. PAY		722. DUTY		723. STATUS		724. GRADE		725. PAY		726. DUTY		727. STATUS		728. GRADE		729. PAY		730. DUTY		731. STATUS		732. GRADE		733. PAY		734. DUTY		735. STATUS		736. GRADE		737. PAY		738. DUTY		739. STATUS		740. GRADE		741. PAY		742. DUTY		743. STATUS		744. GRADE		745. PAY		746. DUTY		747. STATUS		748. GRADE		749. PAY		750. DUTY		751. STATUS		752. GRADE		753. PAY		754. DUTY		755. STATUS		756. GRADE		757. PAY		758. DUTY		759. STATUS		760. GRADE		761. PAY		762. DUTY		763. STATUS		764. GRADE		765. PAY		766. DUTY		767. STATUS		768. GRADE		769. PAY		770. DUTY		771. STATUS		772. GRADE		773. PAY		774. DUTY		775. STATUS		776. GRADE		777. PAY		778. DUTY		779. STATUS		780. GRADE		781. PAY		782. DUTY		783. STATUS		784. GRADE		785. PAY		786. DUTY		787. STATUS		788. GRADE		789. PAY		790. DUTY		791. STATUS		792. GRADE		793. PAY		794. DUTY		795. STATUS		796. GRADE		797. PAY		798. DUTY		799. STATUS		800. GRADE		801. PAY		802. DUTY		803. STATUS		804. GRADE		805. PAY		806. DUTY		807. STATUS		808. GRADE		809. PAY		810. DUTY		811. STATUS		812. GRADE		813. PAY		814. DUTY		815. STATUS		816. GRADE		817. PAY		818. DUTY		819. STATUS		820. GRADE		821. PAY		822. DUTY		823. STATUS		824. GRADE		825. PAY		826. DUTY		827. STATUS		828. GRADE		829. PAY		830. DUTY		831. STATUS		832. GRADE		833. PAY		834. DUTY		835. STATUS	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3030

## CERTIFICATE OF DEATH

02970

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7816 Stratford Road</b>		d. STREET ADDRESS <b>7816 Stratford Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>M.</b> Last <b>BECKER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1884</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>17</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>W. Birkle</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Edmund H. Becker, Jr.</b>		Address <b>4821 N. Lane, Beth. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cachexia</b> <b>181X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of urinary bladder</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>7 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential hypertension</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 22, 1949</b> , to <b>March 25, 1956</b> , that I last saw the deceased alive on <b>March 25, 1956</b> , and that death occurred at <b>2:00 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace M. Yater</b>		M.D. <b>1801 K St. N.W., Washington 6, D.C.</b> DATE SIGNED <b>3/26/56</b>	
PHYSICIAN'S NAME (Type) <b>Wallace M. Yater, M.D.</b>		<b>1801 K St. N.W. Washington, D.C.</b> <b>3/26/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-28-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>3-28-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

2.

13724

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3031

## CERTIFICATE OF DEATH

02971

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda, (Rural)</u>				c. LENGTH OF STAY IN 1b <u>1 Mo. 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>51 U.S. Naval Hospital, Bethesda, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Feltie</u> Last <u>BELK</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 June 1905</u>	
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mariner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mariner</u>		11. BIRTHPLACE (State or foreign country) <u>Mississippi</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Deceased</u>				14. MOTHER'S MAIDEN NAME <u>Minnie RONE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-II</u>		17. INFORMANT <u>Mrs. Berenice BELK</u>		Address <u>Bethesda, Md.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW-II</u>		17. INFORMANT <u>Mrs. Berenice BELK</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma (primary site undetermined)</u> <u>1997</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>8 Feb.</u> , 19 <u>56</u> , to <u>12 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12 March</u> , 19 <u>56</u> , and that death occurred at <u>5:55 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. RUPNIK</u>				M.D. <u>U.S. Naval Hospital, Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. J. RUPNIK, LCDR, MC, USN</u>				ADDRESS <u>U.S. Naval Hospital, Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>16 Mar. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. BURIAL DIRECTOR'S SIGNATURE <u>W. H. Stedley</u>				ADDRESS <u>St., N.W. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>S.H. HINES FUNERAL HOME, 2901 14th</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>				DATE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
MARRIAGE		SINGLE		WIDOW		DIVORCED		RE-MARRIED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
OCCUPATION		PROFESSION		INDUSTRY		TRADE		ART		SCIENCE		LITERATURE		OTHER	
EDUCATION		SCHOOL		COLLEGE		UNIVERSITY		OTHER		DATE OF GRADUATION		PLACE OF GRADUATION		CITY	
RELIGION		ETHNIC ORIGIN		RACE		COLOR		HAIR		EYES		SKIN		BUILD	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		HISTORY		PREVIOUS ILLNESS		PREVIOUS SURGERY	
DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		DATE OF INTERMENT		PLACE OF INTERMENT		CITY	
NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CLERGYMAN		NAME OF CHURCH		NAME OF CEMETERY		NAME OF BURIAL		NAME OF CREMATION		NAME OF OTHER	
NAME OF NEXT OF KIN		NAME OF SURVIVOR		NAME OF WITNESS		NAME OF JURY		NAME OF JUDGE		NAME OF CLERK		NAME OF REGISTRAR		NAME OF OTHER	

RECEIVED

BUREAU V. S.

RECEIVED



3032

## CERTIFICATE OF DEATH

02972  
Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7207 Lenhart Dr.</b>				d. STREET ADDRESS <b>7207 Lenhart Dr.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Weyhe Bertelsen</b>				4. DATE OF DEATH Month Day Year <b>March 3, 1956</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March, 12, 1866</b>	9. AGE (In years last birthday) yrs. <b>89</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lemvig, Denmark</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unobtainable</b>				14. MOTHER'S MAIDEN NAME <b>Unobtainable</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Christian W. Bertelsen- 224 Mt. Vernon St. Dedham, Mass.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X Congestive Heart Failure</b> DUE TO (b) <b>Cardo-Vascular Renal Disease</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3 Days 6 Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 1955</b> , to <b>Mar. 3, 1956</b> , that I last saw the deceased alive on <b>March 3, 1956</b> , and that death occurred at <b>8:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Harold Heiges M.D. 1835 Eyest NW DC 3/3/56</b>							
ACTUAL SIGNATURE <b>Harold Heiges</b> M.D. <b>1835 Eyest NW DC 3/3/56</b>							
PHYSICIAN'S NAME (Type) <b>Harold Heiges M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/6/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>L. H. Thines Co., Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>DATE 8-7-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed and filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**3033**  
**CERTIFICATE OF DEATH**

02973

Reg. Dist. No. 216

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float:right">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>4300 Lynbrook Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Robert Winfield</u> <span style="float:right">First Middle Last</span> <b>4. DATE OF DEATH</b> <u>March 26</u> <span style="float:right">Month Day Year</span> 19 <u>56</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>July 3, 1902</u> <b>9. AGE</b> (In years last birthday) <u>53</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>23</u> <b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Pharmacist - Dist. Manager Ropes Drug Stores</u> <b>13. FATHER'S NAME</b> <u>Frances Marion Bond</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Cleveland, Ohio</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sadie Stewart</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.A.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>577-05-9283</u>		<b>17. INFORMANT</b> <u>Wife - Fern B. Bond</u> <span style="float:right">Address</span> <u>- above</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction acute</u> DUE TO <u>coronary occlusion</u> (b) <u>Arteriosclerosis generalized</u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 1/2 hours</u> <u>5 1/2 years</u> <u>10 1/2 years</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u></u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. p. <u>19</u> p. m. <u></u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u> <b>20f. (City or town)</b> (County) (State) <u></u>			
<b>21. I certify</b> that I attended the deceased from <u>3/26/56</u> , 19 <u>56</u> , to <u>3/26/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/26</u> , 19 <u>56</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <u>Charles J. Savarese, Jr.</u> <span style="float:right">M.D.</span>		<b>ADDRESS</b> (Street, city or town, state) <u>4861 BATTERY LANE</u> <b>DATE SIGNED</b> <u>3/26/56</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>CHARLES J. SAVARESE, JR. M.D.</u> <u>BETHESDA, MD.</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3-29-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cem</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Rockville, Maryland</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u> <span style="float:right">ADDRESS</span> <u>Bethesda Md</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>3-28-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4619 Chase Ave.</b>		d. STREET ADDRESS <b>4619 Chase Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>MINNIE</b> First <b>E.</b> Middle <b>BOOTH E</b> Last		4. DATE OF DEATH <b>March 9</b> Month <b>89</b> Day <b>1956</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1882</b> <b>Oct. 16, 1882</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE (In years last birthday) <b>73</b> yrs. <b>4</b> months <b>23</b> days
11. BIRTHPLACE (State or foreign country) <b>N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilson Godfrey</b>		14. MOTHER'S MAIDEN NAME <b>Julia A. Robinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Wm. C. Simmons-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic pyelonephritis +</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure</b> (c) <b>arteriosclerotic heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>3 months</b> <b>several years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month/Day/Year <b>11/45</b> Hour <b>3/9</b> <b>1956</b> p. m.	20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12/1</b> , 19 <b>55</b> , to <b>3/9</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3/8</b> , 19 <b>56</b> , and that death occurred at <b>11:45</b> p. m. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Allen J. O'Neill</b>		ADDRESS (Street, city or town, state) <b>7740 Old Georgetown Rd, Bethesda</b>	
PHYSICIAN'S NAME (Type) <b>Allen J. O'Neill</b>		DATE SIGNED <b>March 10, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit</b>	22b. DATE THEREOF <b>3-11-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hollywood</b>	22d. LOCATION (City, town, or county) (State) <b>Elizabeth City, N. Carolina</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 3-12-56</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>



# CERTIFICATE OF DEATH

Dr Broschart asked for proper procedure in this situation: i.e. Dr Savarese, the usual attending physician being out of town for 10 days and the death pronouncement being made by a physician from the University of Columbia who does not have a Maryland license. Under these circumstances and since the patient was recently in Suburban Hospital for a month for the conditions causing her death, I was advised to sign the certificate.



CERTIFICATE OF DEATH

Reg. Dist. No.

223

2986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. STREET ADDRESS <u>11 Niagara St</u>			
3. NAME OF DECEASED (Type or print) First <u>Mrs Elizabeth</u> Middle <u>Bostelmann</u> Last				4. DATE OF DEATH Month <u>March</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 19 - 1876</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>John Mabe</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Hambrecht</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic H. Disease</u> DUE TO (c) <u>Recent Virus Infection followed by Depression</u>							INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>6 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 26</u> , 19 <u>56</u> , to <u>Mar 26</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar 26</u> , 19 <u>56</u> , and that death occurred at <u>11:55</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Henry E. Andron</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Henry E. Andron, M.D.</u>				DATE SIGNED <u>Mar 26 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Leaneck Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leaneck, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Baulewicz</u> ADDRESS <u>1733 Pa. Avenue</u>				24. REC'D BY REGISTRAR <u>John D. Bell</u> DATE <u>3/28/56</u>		25. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in page 3 should be detached for use as the burial-transit permit.

BUREAU V. S.

RECEIVED

3035

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. LENGTH OF STAY IN 1b <b>118 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>10 E. Henrietta Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Franklyn</b> Last <b>Bowden</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1933</b>
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min.	IF UNDER 24 HRS. Months <b>23</b> Days <b>23</b> Hours <b>23</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Traffic Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Light</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Bowden</b>	
14. MOTHER'S MAIDEN NAME <b>Stella Jewell</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>216-28-0979</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3 Bleeding from Tracheo-esophageal fistula</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hodgkins Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 12, 1955</b> , to <b>March 16, 1956</b> , that I last saw the deceased alive on <b>March 16, 1956</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Claude E. Forkner</b> (as per Dr. John Tarkenton) M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>March 16, 1956</b>	
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, M.D.</b>		National Institutes of Health Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/19/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, Inc.</b>		ADDRESS <b>715 Light St.</b>	
24a. REC'D BY REGISTRAR <b>March 17, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Ruth Mary E. Farrelly</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete the certificate has been signed by the attending physician and complete the certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 20 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02977

2987

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>MONTGOMERY</u>		STATE <u>MARYLAND</u>		STATE <u>DC</u>		COUNTY <u>WASHINGTON</u>	
CITY (If outside corporate limits, write nearest town) <u>TAKOMA PARK</u>		LENGTH OF STAY (in this place) <u>8 DAYS</u>		CITY (If outside corporate limits, write nearest town) <u>WASHINGTON, DC</u>		TOWN <u>47K-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>700 HUDSON AVE.</u>				STREET ADDRESS (If rural give location) <u>306 EMERSON ST. N.W.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>GOLDIE BOZIN</u>				<b>4. DATE OF DEATH</b> (Month) <u>MARCH</u> (Day) <u>2</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>?</u>	<b>9. AGE last birthday</b> <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>RUSSIA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>ABE BRILLMAN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>UNK.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>SAMUEL BOZIN - 306 EMERSON ST. N.W. DC</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>445X IMMEDIATE CAUSE (A)</b> <u>RENAL FAILURE</u>						<u>2 days</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>MALIGNANT HYPERTENSION</u>						<u>UNKNOWN</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b> <u>CEREBRAL ATROPHY</u>						<u>2 MONTHS</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>FEB 27, 1956</u>, to <u>MAR 2, 1956</u>, that I last saw the deceased alive on <u>MAR 2, 1956</u>, and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Arthur S. Brinkman</u>				<b>DATE SIGNED</b> <u>3-2-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>REMOVAL - BURIAL</u>				<b>DATE THEREOF</b> <u>3/4/1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>GOODMAN-BANKMAN FUNK HOME MILWAUKEE Wisc.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>3-5-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Richard D. ...</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Shelley ...</u>		<b>ADDRESS</b> <u>4217-9th Ave NW DC</u>	



RECEIVED



3036

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>1324 Staples Street, N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Ernest</b> Middle <b>Blake</b> Last <b>BRYANT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-12-94</b>	9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Jucius BRYANT</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth JONES</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Friend Mrs. Lucille M. HARLEY</b>		Address <b>Same as item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Syphilis, Cardiovascular &amp; cardiomegaly</b> DUE TO (c) <b>Nephrosclerosis &amp; uremia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>18 mos</b> <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(d) Bronchopneumonia due to Staphylococcus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>28 Dec</b> , 19 <b>55</b> , to <b>23 Mar</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>23 Mar</b> , 19 <b>56</b> , and that death occurred at <b>1:35A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>LT, MC, USNH, NNMC, Bethesda, Maryland</b>							
ACTUAL SIGNATURE <b>J. T. Horgan</b>							
PHYSICIAN'S NAME (Type) <b>J. T. HORGAN LT, MC, USN USNH, NNMC, Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>28 Mar 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. [Signature]</b>				24a. REC'D BY REGISTRAR <b>Lee Funeral Home</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>	
ADDRESS <b>4th and Mass Ave NE. Wash, D.C.</b>				DATE <b>23 Mar 56</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3-56

415

Name of Deceased		Date of Death		Place of Death	
J. T. HICKMAN, JR., MD, USA		MAR 20 1956		BALTIMORE, MD	
Age		Sex		Race	
37		M		W	
Date of Birth		Place of Birth		Cause of Death	
MAR 23 1919		BALTIMORE, MD		HEART DISEASE	
Occupation		Manner of Death		Signature of Physician	
Surgeon General		Natural		J. T. HICKMAN, JR., MD, USA	
Signature of Registrar		Date of Registration		Place of Registration	
J. T. HICKMAN, JR., MD, USA		MAR 27 1956		BALTIMORE, MD	

RECEIVED  
BUREAU V. S.  
MAR 27 1956

3037

## CERTIFICATE OF DEATH

02979

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>121 Peabody Street, N.W.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>William George BUCHANAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-31-77</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Ireland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>John BUCHANAN</b>				14. MOTHER'S MAIDEN NAME <b>Agnes RHOMESON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Wife Mrs. Nadine B. BUCHANAN</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emboli</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>17 Feb 1956</b> to <b>10 Mar 1956</b> , that I last saw the deceased alive on <b>10 Mar 1956</b> , and that death occurred at <b>7:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>R. G. Williams</b>				M.D. <b>USNH, NNMC, Bethesda, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>R. G. WILLIAMS LCDR USN (MC)</b>				<b>USNH, NNMC, Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>14 Mar 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Co Hill</b>				24a. REC'D BY REGISTRAR <b>HINES Funeral Home, 2901 14th Street, N.W. Washington, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parselly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 602

RECEIVED

13 MAR 1956

BUREAU V. S.

3038

## CERTIFICATE OF DEATH

02980

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00</b>		d. STREET ADDRESS <b>6810 GLENBROOK RD.</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSIA</b> Middle <b>BURCH</b> Last <b>BURCH</b>		4. DATE OF DEATH Month <b>3</b> - Day <b>24</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-8-73</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR: Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>STEVE BURCH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>0</b>	
17. INFORMANT <b>FRED H. UGAST</b>		Address <b>6810 GLENBROOK RD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure, acute</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension, essential, severe</b> DUE TO <b>2 yrs +</b> (c) <b>Arteriosclerosis, generalised</b> <b>5 yrs +</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left hemiplegia 2.3.56 + Bronchopneumonia left lung</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. p.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-16-1956</b> , to <b>3-24-1956</b> , that I last saw the deceased alive on <b>3-24-1956</b> , and that death occurred at <b>5:20 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stewart Clapp</b>		ADDRESS (Street, city or town, state) <b>Wash DC</b> DATE SIGNED <b>3-24-56</b>	
PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D.</b>		M.D. <b>3921 Ingomar St N.W.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis G. Collins</b>		ADDRESS <b>3821-14th NW</b>	
24a. REC'D BY REGISTRAR <b>DATE 8-27-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bernie M. Thompson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 1 3918

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02981  
Reg. Dist.

No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rockville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Rockville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>826 Crothers Lane</u>				STREET ADDRESS (If rural, give location) <u>826 Crothers Lane</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Stephen Patrick Burgess</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 4 1956</u>			
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11-7-55</u>	9. AGE last birthday: yrs. <u>3</u> Months <u>27</u> Days <u>27</u> Hours <u></u> Min. <u></u>	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u></u>			10b. KIND OF BUSINESS OR INDUSTRY: <u></u>		11. BIRTHPLACE (State or foreign country): <u>Washington DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USC</u>
13. FATHER'S NAME: <u>Ward Burgess</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Catherine Campbell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Ward Burgess (father) Same as dec'd</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Asphyxia due to vomiting</u>						<u>Found dead in bed.</u>	
DUE TO							
Antecedent cause(s) (b) <u>Upper Respiratory Infection</u>							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19a. DATE OF OPERATION: <u></u>				19b. MAJOR FINDING OF OPERATION: <u></u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				(State)			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M. <u></u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u></u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschait</u>		M. D. <u></u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-4-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
DATE REC'D BY LOCAL REG. <u>3/7/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bragdon</u>		24. FUNERAL DIRECTOR ADDRESS <u>Robert A. Pumphrey Bethesda, Md.</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3039 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02982  
Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Olney</b>		c. LENGTH OF STAY IN 1b <b>4 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Route 1 - Silver Spring X</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>73 Montgomery County General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Andrew</b> Middle <b>Jackson</b> Last <b>Burriss</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>23</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/15/1872</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER &amp; TENANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Burriss</b>				14. MOTHER'S MAIDEN NAME <b>Unknown by Family</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>NONE</b>		17. INFORMANT <b>Daughter</b>		Address <b>Same As above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> <b>903.0</b> DUE TO <b>fracture of Neck of Lt. Femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b></b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on Floor At Home</b>					
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>3/18</b> 19 <b>56</b> <b>p. m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>RT. #1, Silver Spring, Mont</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart, M. D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE UNION CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bertine B Lawler</b>			

MASSACHUSETTS DEPARTMENT OF HEALTH—BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3040

CERTIFICATE OF DEATH

02983

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Potomac</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Potomac</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R. F. D. # 3. Bethesda.</b>				d. STREET ADDRESS <b>R. F. D. # 3. Bethesda</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>S.</b> Last <b>CASE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>25</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 26, 1984</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>29</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>				13. FATHER'S NAME <b>Charles A. Case</b>			
14. MOTHER'S MAIDEN NAME <b>Emma D. Fisher</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>--</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>J. B. Case- Item # 2</b> Address <b></b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction - coronari</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>Indef</b> <b>Indef</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b> (County) <b></b> (State) <b></b>				21. I certify that I attended the deceased from <b>3/12/56</b> , 19 <b>56</b> , to <b>3/25/56</b> , 19 <b>56</b> that I last saw the deceased alive on <b>3/25/56</b> , 19 <b>56</b> , and that death occurred at <b>1:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D. <b>Robert A. Pumphrey</b>				ADDRESS (Street, city or town, state) <b></b> DATE SIGNED <b>3/26/56</b>			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones- Rockville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-28-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b> ADDRESS <b></b>				24a. REC'D BY REGISTRAR <b>3-28-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

BUREAU V. S.

MAR 29 1956

RECEIVED

3041

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda (rural)</u>				c. LENGTH OF STAY IN 1b <u>1 Mo. 1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>51 U.S. Naval Hospital, NMMC</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>56</u>			
f. STREET ADDRESS <u>2418 Homestead Drive</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Kathleen</u> <u>(n) CATRAMBONE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-30-55</u>	
9. AGE (In years last birthday) <u>3</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Bethesda, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>James CATRAMBONE</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth COLLINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS. Elizabeth CATRAMBONE</u> <u>2418 Homestead Drive, Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>754.2 Congestive heart failure</u> DUE TO (b) <u>Patent ductus Congenital heart disease - i.v. septal defect</u> DUE TO (c) <u>3 1/2 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>10 Feb.</u> , 19 <u>56</u> , to <u>11 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11 March</u> , 19 <u>56</u> , and that death occurred at <u>8:35 P</u> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Howard A. Pearson</u> M.D.				U.S. Naval Hospital, NMMC, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <u>HOWARD A. PEARSON, LT, MC, USN</u>				U.S. Naval Hospital, NMMC, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 Mar. 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Evangelist Parish</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. PUMPHREY</u>				ADDRESS <u>8434 Georgia Ave., Silver Spring</u>		24a. REC'D BY REGISTRAR <u>Mary G. Parrelly</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2051 201393

7, 1997

BUREAU V. S.

MAR 13 1956

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**MEDICAL CERTIFICATION**

VS A15 (4)  
ISM 9/SS



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. DATE OF BIRTH		11. SEX OF BIRTH		12. AGE AT BIRTH	
13. DATE OF DEATH		14. TIME OF DEATH		15. PLACE OF DEATH	
16. CAUSE OF DEATH		17. MANNER OF DEATH		18. PLACE OF BIRTH	
19. DATE OF BIRTH		20. SEX OF BIRTH		21. AGE AT BIRTH	
22. DATE OF DEATH		23. TIME OF DEATH		24. PLACE OF DEATH	
25. CAUSE OF DEATH		26. MANNER OF DEATH		27. PLACE OF BIRTH	
28. DATE OF BIRTH		29. SEX OF BIRTH		30. AGE AT BIRTH	
31. DATE OF DEATH		32. TIME OF DEATH		33. PLACE OF DEATH	
34. CAUSE OF DEATH		35. MANNER OF DEATH		36. PLACE OF BIRTH	
37. DATE OF BIRTH		38. SEX OF BIRTH		39. AGE AT BIRTH	
40. DATE OF DEATH		41. TIME OF DEATH		42. PLACE OF DEATH	
43. CAUSE OF DEATH		44. MANNER OF DEATH		45. PLACE OF BIRTH	
46. DATE OF BIRTH		47. SEX OF BIRTH		48. AGE AT BIRTH	
49. DATE OF DEATH		50. TIME OF DEATH		51. PLACE OF DEATH	
52. CAUSE OF DEATH		53. MANNER OF DEATH		54. PLACE OF BIRTH	
55. DATE OF BIRTH		56. SEX OF BIRTH		57. AGE AT BIRTH	
58. DATE OF DEATH		59. TIME OF DEATH		60. PLACE OF DEATH	
61. CAUSE OF DEATH		62. MANNER OF DEATH		63. PLACE OF BIRTH	
64. DATE OF BIRTH		65. SEX OF BIRTH		66. AGE AT BIRTH	
67. DATE OF DEATH		68. TIME OF DEATH		69. PLACE OF DEATH	
70. CAUSE OF DEATH		71. MANNER OF DEATH		72. PLACE OF BIRTH	
73. DATE OF BIRTH		74. SEX OF BIRTH		75. AGE AT BIRTH	
76. DATE OF DEATH		77. TIME OF DEATH		78. PLACE OF DEATH	
79. CAUSE OF DEATH		80. MANNER OF DEATH		81. PLACE OF BIRTH	
82. DATE OF BIRTH		83. SEX OF BIRTH		84. AGE AT BIRTH	
85. DATE OF DEATH		86. TIME OF DEATH		87. PLACE OF DEATH	
88. CAUSE OF DEATH		89. MANNER OF DEATH		90. PLACE OF BIRTH	
91. DATE OF BIRTH		92. SEX OF BIRTH		93. AGE AT BIRTH	
94. DATE OF DEATH		95. TIME OF DEATH		96. PLACE OF DEATH	
97. CAUSE OF DEATH		98. MANNER OF DEATH		99. PLACE OF BIRTH	
100. DATE OF BIRTH		101. SEX OF BIRTH		102. AGE AT BIRTH	

RECEIVED  
MAR 22 1956  
BUREAU V. S.





Item 12, Film 191 3-19-56 et  
 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md.</u>	COUNTY <u>Prince Georges</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Landover Hills</u>	16 x 2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Resmore San. 5721 Grosvenor Lane</u>		STREET ADDRESS (If rural give location) <u>6708 Redfield Ave.</u>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Fernande</u>	(Middle) <u>Cosgrove</u>	OF DEATH: 3	1 1956
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Legally Separated</u>	8. DATE OF BIRTH: <u>6-28-1892</u>
9. AGE last birthday <u>63</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Coverness</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13. FATHER'S NAME: <u>UNRECORDED JULES LECONTE</u>	14. MOTHER'S MAIDEN NAME: <u>UNRECORDED Emma Mengodan</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>023-16-4924</u>
17. INFORMANT & ADDRESS: <u>Edward Cosgrove - 6708 Redfield Ave., Landover Hills, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>		<u>8 hrs.</u>
ANTECEDENT CAUSE (B) <u>Reticulum cell Sarcoma of Ovary with liver metastases</u>		<u>3 months</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>auricular fibrillation &amp; decompensation</u>		<u>2 months</u>
(C) <u>Diabetes mellitus</u>		<u>4 yrs.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>simple gutta serena</u>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1954, to 3/1, 1956, that I last saw the deceased alive on 3/1, 1956, and that death occurred at 1:55 M, from the causes and on the date stated above.

SIGNATURE <u>[Signature]</u>	DATE THEREOF <u>3/1/56</u>	NAME OF CEMETERY OR CREMATORY <u>---</u>	LOCATION (City, town, or county) (State) <u>Mt. Rainier, Md.</u>
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Removal</u>	DATE REC'D BY LOCAL REGISTRAR <u>3-1-56</u>	REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	24. FUNERAL DIRECTOR ADDRESS <u>NAILEYS FUNERAL HOME INC 3200 B. ISLAND AVE., MT. RAINIER, M.D.</u>

BUREAU V. S.

MAR 5 1956

RECEIVED



3045

## CERTIFICATE OF DEATH

02988

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>South Carolina</b> b. COUNTY <b>- -</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>9 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b> <b>National Institutes of Health</b>				e. STREET ADDRESS <b>208 S. Saluda Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>William David Crenshaw</b>				4. DATE OF DEATH <b>March 14 1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 25, 1896</b>	
9. AGE (In years last birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR <b>9</b> Months <b>29</b> Days		11. IF UNDER 24 HRS. <b>9</b> Hours <b>29</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Newspaper foreman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Publishing</b>			
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John W. Crenshaw</b>				14. MOTHER'S MAIDEN NAME <b>Jenny Galloway</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>The medical record, The Clinical Center</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma</b> DUE TO <b>200.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>New bacillus septium &amp; interstitial emphysema of chest &amp; face</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>March 5, 1956</b> , to <b>March 14, 1956</b> , that I last saw the deceased alive on <b>March 14, 1956</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/15/56</b> ACTUAL SIGNATURE <b>Herbert J. Levine M.D.</b> M.D. <b>National Institutes of Health</b> PHYSICIAN'S NAME (Type) <b>Herbert J. Levine, M. D.</b> <b>Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>3-14-56</b>			
22c. NAME OF CEMETERY OR CREMATORY _____				22d. LOCATION (City, town, or county) <b>Columbia</b> (State) <b>So. Carolina</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>			
24a. REC'D BY REGISTRAR <b>3-16-56</b>				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completed certificate shall be filed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

MAR 19 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 2988 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

02989

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN TB <u>15 days</u>		d. STREET ADDRESS <u>10014 Dallas Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Shady Side Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr Ferdinand Joseph Crovato</u>		4. DATE OF DEATH Month Day Year <u>March 14 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 28 1907</u>
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mech Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A. - New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Santo Crovato</u>		14. MOTHER'S MAIDEN NAME <u>Erminia (unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho-pneumonia</u> DUE TO <u>151X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of liver</u> DUE TO <u>Carcinoma of stomach</u> (c) <u>Operative &amp; Exploratory Laparotomy &amp; Liver Biopsy 3-6-56</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few days</u> <u>unknown</u> <u>3 months +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Operative &amp; Exploratory Laparotomy &amp; Liver Biopsy 3-6-56</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 5, 1956</u> to <u>March 14, 1956</u> that I last saw the deceased alive on <u>Mar 11, 1956</u> , and that death occurred at <u>4:21 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Read N. Calvert</u> M.D.		ADDRESS (Street, city or town, state) <u>7894 Georgia Ave, Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>READ N. CALVERT, M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John Cemetery, Silver Spring, Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Haddon - 3831-26 on N.W.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>3-15-56</u>		24b. REGISTRAR'S SIGNATURE <u>John P. Dodd</u>	

# CERTIFICATE OF DEATH

2298

1956

MAR 16

1956

BUREAU V. A.

RECEIVED

8-17-25  
 8-17-25  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After this certificate has been signed by the attending physician and completed, it should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02990

3046

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>				c. LENGTH OF STAY IN 1b <b>25 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Louis</b>		First <b>Louis</b> Middle <b>(none)</b> Last <b>CUKELA</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 May 1888</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>Yugoslavia</b>	
13. FATHER'S NAME <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY? <b>US</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>(Wife) Mrs. Minnie S. CUKELA</b>				Address <b>Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculosis, Lungs and Adrenals</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Laennec's cirrhosis, Atherosclerosis, Arteriosclerosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>24 Feb.</b> 19 <b>56</b> , to <b>19 March</b> 19 <b>56</b> , that I last saw the deceased alive on <b>19 March</b> 19 <b>56</b> , and that death occurred at <b>2:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Md.</b> DATE SIGNED <b>3-20-56</b>							
ACTUAL SIGNATURE <b>J. R. Davis</b>		M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>					
PHYSICIAN'S NAME (Type) <b>J. R. DAVIS, CDR, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-22-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Wisc. Ave. Beth. Md.</b>		24. REGISTRAR'S SIGNATURE <b>Mary E. Cassally</b>	



RECEIVED

CERTIFICATE OF DEATH

02991

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>37 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dunkirk</b>		d. STREET ADDRESS <b>no street address</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>Cullember</b>		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1903</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James W. Cullember</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-34-8605</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Calcific Aortic Stenosis, postoperative</b> <b>421.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hemopericardium</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2+ yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 12, 1956</b> , to <b>March 20, 1956</b> , that I last saw the deceased alive on <b>March 20, 1956</b> , and that death occurred at <b>5:10 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Kaiser</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>3/20/56</b>	
PHYSICIAN'S NAME (Type) <b>George C. Kaiser, M. D.</b>		National Institutes of Health Bethesda, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/23/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lothian Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas Hutchins</b>		ADDRESS <b>Owings Md</b>	
24a. REC'D BY REGISTRAR <b>Benie M. Thompson</b>		24b. REGISTRAR'S SIGNATURE <b>Benie M. Thompson</b>	

CERTIFICATE OF DEATH

Name of Deceased [Illegible]		Sex [Illegible]		Date of Birth [Illegible]	
Usual Residence [Illegible]		Place of Birth [Illegible]		Date of Death [Illegible]	
Cause of Death [Illegible]		Immediate Cause [Illegible]		Manner of Death [Illegible]	
Physician's Name [Illegible]		Hospital Name [Illegible]		Date of Admission [Illegible]	
Name of Informant [Illegible]		Relationship [Illegible]		Signature of Informant [Illegible]	
Name of Registrar [Illegible]		Signature of Registrar [Illegible]		Date of Registration [Illegible]	

RECEIVED  
 MAR 28 1956  
 BUREAU V. S.

3048

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>BROOKE GROVE CONVALESCENT HOME</b>		d. STREET ADDRESS <b>9707 LAWDALE DRIVE</b>	
3. NAME OF DECEASED (Type or print) First <b>MELVIN</b> Middle <b>A.</b> Last <b>CUMMINGS</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 15, 1864</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER, RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WALTER S. CUMMINGS</b>		14. MOTHER'S MAIDEN NAME <b>MARY BARLOW</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. ARTHUR M. CUMMINGS</b>		Address <b>9707 LAWDALE DRIVE SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (recurrences)</b> <b>593X</b> DUE TO <b>&amp; Nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 year</b> (c) <b>32 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 13</b> , 19 <b>56</b> , to <b>Mar 15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Feb 13</b> , 19 <b>56</b> , and that death occurred at <b>5:55 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John N. Andrews</b>		ADDRESS (Street, city or town, state) <b>9601 Colesville Rd. Silver Spring, Md</b>	
PHYSICIAN'S NAME (Type) <b>John N. Andrews, M.D.</b>		DATE SIGNED <b>3-16-56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>3/19/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FOWLER CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FOWLER, MEADE COUNTY, KANSAS</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3-17-56</b>		24b. REGISTRAR'S SIGNATURE <b>Gertrude B. Lawler</b>	

CERTIFICATE OF DEATH

5048

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. RACE                  [REDACTED]</p>	
<p>5. DATE OF BIRTH                  [REDACTED]</p>		<p>6. PLACE OF BIRTH                  [REDACTED]</p>	
<p>7. DATE OF DEATH                  [REDACTED]</p>		<p>8. PLACE OF DEATH                  [REDACTED]</p>	
<p>9. CAUSE OF DEATH                  [REDACTED]</p>		<p>10. MANNER OF DEATH                  [REDACTED]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>		<p>12. SIGNATURE OF REGISTRAR                  [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>15. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>16. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>17. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>18. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>19. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>20. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>21. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>22. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>23. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>24. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>25. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>26. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>27. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>28. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>29. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>30. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>31. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>32. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>33. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>34. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>35. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>36. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>37. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>38. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>39. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>40. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>41. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>42. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>43. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>44. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>45. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>46. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>47. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>48. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>49. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>50. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>51. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>52. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>53. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>54. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>55. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>56. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>57. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>58. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>59. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>60. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>61. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>62. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>63. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>64. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>65. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>66. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>67. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>68. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>69. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>70. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>71. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>72. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>73. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>74. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>75. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>76. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>77. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>78. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>79. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>80. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>81. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>82. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>83. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>84. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>85. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>86. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>87. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>88. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>89. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>90. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>91. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>92. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>93. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>94. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>95. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>96. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>97. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>98. SIGNATURE OF WITNESS                  [REDACTED]</p>	
<p>99. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>100. SIGNATURE OF WITNESS                  [REDACTED]</p>	

BUREAU V. H.

MAR 20 1956

RECEIVED



3049

## CERTIFICATE OF DEATH

02993

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY <u>47x-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban</u>		d. STREET ADDRESS <u>3915 Ingomar St. NW</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>May</u> Last <u>Cutcheon</u>		4. DATE OF DEATH Month <u>March</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-12-68</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles ARMOR</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Klotter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Burgess, Herbert</u>		Address <u>7523 Hampton La. Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Peritonitis</u> <u>541.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Sigmoidal ulcer</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>22 hrs</u> <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 1, 1956</u> , to <u>March 6, 1956</u> , that I last saw the deceased alive on <u>March 6, 1956</u> , and that death occurred at <u>9:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>3921 Ingomar St. NW, Wash. D.C.</u>			
ACTUAL SIGNATURE <u>Sidney G. Cousins</u>		M.D. <u>3921 Ingomar St. NW, Wash. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Sidney G. Cousins- 3921 Ingomar St., N.W.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-8-56</u>	24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH	
JAMES EARL RAY		M		35		W		12/1/28		MEMPHIS, TENN		4/4/68		MEMPHIS, TENN	
9. OCCUPATION		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. MEDICAL HISTORY		13. PRESENT ILLNESS		14. TREATMENT		15. POSTMORTEM EXAMINATION		16. SIGNATURE OF PHYSICIAN	
ATTORNEY		HEART DISEASE		NATURAL		NO		HEART DISEASE		NO		NO		JAMES EARL RAY	
17. SIGNATURE OF CORONER		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS		22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

BUREAU V. S.

MAR 12 1968

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 223-

2989

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>District of Columbia</u>			
c. LENGTH OF STAY IN 1b <u>2 hrs.</u>				d. STREET ADDRESS <u>1640 Crittenden St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Henry</u> Last <u>Davenport</u> Sr.				4. DATE OF DEATH Month <u>3</u> - Day <u>15</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-13-95</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Advertising</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Star.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel L. Davenport</u>		14. MOTHER'S MAIDEN NAME <u>Helen Duvall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WV-1-Army</u>		17. INFORMANT <u>Hospital Records</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Occlusion</u> DUE TO (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 hrs.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>March 14, 1955</u> , to <u>March 15, 1955</u> , that I last saw the deceased alive on <u>March 15, 1955</u> , and that death occurred at <u>3:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Whitlock</u>				ADDRESS (Street, city or town, state) <u>Takoma Park 12 Md.</u>			
PHYSICIAN'S NAME (Type) <u>James M. Whitlock M.D.</u>				DATE SIGNED <u>Takoma Park 12 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		22d. LOCATION (City, town, or county) <u>Wash. D.C.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>West Funeral Home</u>				ADDRESS <u>4812 La Ave. N.W.</u>		24a. REC'D BY REGISTRAR <u>3/19/56</u> 24b. REGISTRAR'S SIGNATURE <u>J. M. DODD</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



305D

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Ashton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> 16-41-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Route 29</u>				d. STREET ADDRESS <u>307 9th Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Doris</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 2, 1884</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>30</u> Min. <u>00</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>15</u> Hours <u>30</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Upper Marlboro, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Richard Laneless</u>				14. MOTHER'S MAIDEN NAME <u>Rose Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT <u>Mrs. William Bassett Ashton, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 3 days 443X DUE TO (b) <u>Hypertensive C.-V. Disease</u> 15 yrs DUE TO (c) <u>Gen'l Arteriosclerosis</u> 18 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Dementia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>7/1</u> , 19 <u>56</u> , to <u>3/23</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/23</u> , 19 <u>56</u> , and that death occurred at <u>7</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. M. Warren</u> M.D.				ADDRESS (Street, city or town, state) <u>305 Prince Georges Lane Laurel 3/23</u>			
PHYSICIAN'S NAME (Type) <u>J. M. Warren</u> <u>Laurel, Maryland</u>				DATE SIGNED <u>Burtonville 56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>Mar 25-56</u>			
22c. NAME OF CEMETERY OR CREMATOR <u>Union</u>				22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Kincaid</u> <u>Laurel Md.</u>				ADDRESS			
24a. REC'D BY REGISTRAR <u>DATE 3-27-56</u>				24b. REGISTRAR'S SIGNATURE <u>Bertie B. Lawler</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3051

## CERTIFICATE OF DEATH

02996

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp-</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Harry Edward Davis</u>		4. DATE OF DEATH Month Day Year <u>March 3 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1900</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dist. Water Dept.</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Woretta Soper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Wife, Mary Estelle Davis - above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diffuse Collagen Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Periarteritis nodosa</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Abscesses Skin Subcutaneous</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1955</u> , to <u>Mar 3, 1956</u> , that I last saw the deceased alive on <u>Mar 3, 1956</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u>		DATE SIGNED <u>3/3/56</u>	
PHYSICIAN'S NAME (Type) <u>John J. Curry</u>		M.D. <u>11301 Georgia Ave S.E.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 7</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ray W. Barber</u>		ADDRESS <u>Laytonville, Ind</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-6-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	



3052

## CERTIFICATE OF DEATH

**MEDICAL CERTIFICATION**

VS A15 (4)  
15M 9/55

CERTIFICATE OF DEATH

Name of Deceased Robert A. Murphy - Bethesda, Maryland		Date of Death April 25, 1956	
Age 34		Sex Male	
Race White		Marital Status Married	
Place of Birth Bethesda, Maryland		Usual Residence Bethesda, Maryland	
Cause of Death Heart Disease - I.C.D.		Manner of Death Natural	
Physician's Signature [Signature]		Date of Report April 25, 1956	
Hospital or Place of Death Bethesda Hospital		Name of Attending Physician [Signature]	
Name of Informant Mary Murphy		Relationship to Deceased Wife	
Signature of Informant [Signature]		Date of Signature April 25, 1956	
Signature of Registrar [Signature]		Date of Registration April 25, 1956	

RECEIVED  
MAR 29 1956  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

02998  
223

2990

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Indiana</i> b. COUNTY <i>MISHAWAKA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>17 Foxoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52x-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>75 Washington Sanitarium</i>		d. STREET ADDRESS <i>620 WEST GROVE STREET</i>	
3. NAME OF DECEASED (Type or print) <i>FRANK XAVIER DeClercq</i>		4. DATE OF DEATH <i>3-1-56</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>Cauc</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-12-80</i>
9. AGE (In years last birthday) <i>75</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired - US Rubber Co</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Indiana</i>	
11. BIRTHPLACE (State or foreign country) <i>America</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>August DeClercq</i>		14. MOTHER'S MAIDEN NAME <i>Octavia Van Huffell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Neice - 10140 Southernland Rd.</i>	
17. INFORMANT <i>Mrs Marion Mahoney</i>		Address <i>10140 Southernland Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493x Hypoplastic Anemia</i> DUE TO (b) <i>Pneumonia Dec 1955</i> DUE TO (c) <i>2 mo. ago</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5.5</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-20-56</i> , 1956, to <i>Mar 1</i> , 1956, that I last saw the deceased alive on <i>Mar 1</i> , 1956, and that death occurred at <i>9:55 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John N. Andrews</i>		ADDRESS (Street, city or town, state) <i>9601 Colesville Rd Silver Spring Md</i>	
PHYSICIAN'S NAME (Type) <i>JOHN N. ANDREWS</i>		DATE SIGNED <i>3-1-56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>TRANS &amp; BURIAL</i>		22b. DATE THEREOF <i>3/5/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>ST. JOSEPH'S CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>MISHAWAKA, INDIANA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Warner &amp; Humphrey</i>		ADDRESS <i>SILVER SPRING, MARYLAND</i>	
24a. REC'D BY REGISTRAR <i>DATE 3-3-56</i>		24b. REGISTRAR'S SIGNATURE <i>John D. Dalt</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]	
3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]	
7. MARITAL STATUS [Faint text]		8. CAUSE OF DEATH [Faint text]	
9. PLACE OF DEATH [Faint text]		10. TIME OF DEATH [Faint text]	
11. SIGNATURE OF PHYSICIAN [Faint text]		12. SIGNATURE OF REGISTRAR [Faint text]	
13. SIGNATURE OF WITNESS [Faint text]		14. SIGNATURE OF DECEASED [Faint text]	
15. SIGNATURE OF DECEASED [Faint text]		16. SIGNATURE OF DECEASED [Faint text]	
17. SIGNATURE OF DECEASED [Faint text]		18. SIGNATURE OF DECEASED [Faint text]	
19. SIGNATURE OF DECEASED [Faint text]		20. SIGNATURE OF DECEASED [Faint text]	
21. SIGNATURE OF DECEASED [Faint text]		22. SIGNATURE OF DECEASED [Faint text]	
23. SIGNATURE OF DECEASED [Faint text]		24. SIGNATURE OF DECEASED [Faint text]	
25. SIGNATURE OF DECEASED [Faint text]		26. SIGNATURE OF DECEASED [Faint text]	
27. SIGNATURE OF DECEASED [Faint text]		28. SIGNATURE OF DECEASED [Faint text]	
29. SIGNATURE OF DECEASED [Faint text]		30. SIGNATURE OF DECEASED [Faint text]	
31. SIGNATURE OF DECEASED [Faint text]		32. SIGNATURE OF DECEASED [Faint text]	
33. SIGNATURE OF DECEASED [Faint text]		34. SIGNATURE OF DECEASED [Faint text]	
35. SIGNATURE OF DECEASED [Faint text]		36. SIGNATURE OF DECEASED [Faint text]	
37. SIGNATURE OF DECEASED [Faint text]		38. SIGNATURE OF DECEASED [Faint text]	
39. SIGNATURE OF DECEASED [Faint text]		40. SIGNATURE OF DECEASED [Faint text]	
41. SIGNATURE OF DECEASED [Faint text]		42. SIGNATURE OF DECEASED [Faint text]	
43. SIGNATURE OF DECEASED [Faint text]		44. SIGNATURE OF DECEASED [Faint text]	
45. SIGNATURE OF DECEASED [Faint text]		46. SIGNATURE OF DECEASED [Faint text]	
47. SIGNATURE OF DECEASED [Faint text]		48. SIGNATURE OF DECEASED [Faint text]	
49. SIGNATURE OF DECEASED [Faint text]		50. SIGNATURE OF DECEASED [Faint text]	
51. SIGNATURE OF DECEASED [Faint text]		52. SIGNATURE OF DECEASED [Faint text]	
53. SIGNATURE OF DECEASED [Faint text]		54. SIGNATURE OF DECEASED [Faint text]	
55. SIGNATURE OF DECEASED [Faint text]		56. SIGNATURE OF DECEASED [Faint text]	
57. SIGNATURE OF DECEASED [Faint text]		58. SIGNATURE OF DECEASED [Faint text]	
59. SIGNATURE OF DECEASED [Faint text]		60. SIGNATURE OF DECEASED [Faint text]	
61. SIGNATURE OF DECEASED [Faint text]		62. SIGNATURE OF DECEASED [Faint text]	
63. SIGNATURE OF DECEASED [Faint text]		64. SIGNATURE OF DECEASED [Faint text]	
65. SIGNATURE OF DECEASED [Faint text]		66. SIGNATURE OF DECEASED [Faint text]	
67. SIGNATURE OF DECEASED [Faint text]		68. SIGNATURE OF DECEASED [Faint text]	
69. SIGNATURE OF DECEASED [Faint text]		70. SIGNATURE OF DECEASED [Faint text]	
71. SIGNATURE OF DECEASED [Faint text]		72. SIGNATURE OF DECEASED [Faint text]	
73. SIGNATURE OF DECEASED [Faint text]		74. SIGNATURE OF DECEASED [Faint text]	
75. SIGNATURE OF DECEASED [Faint text]		76. SIGNATURE OF DECEASED [Faint text]	
77. SIGNATURE OF DECEASED [Faint text]		78. SIGNATURE OF DECEASED [Faint text]	
79. SIGNATURE OF DECEASED [Faint text]		80. SIGNATURE OF DECEASED [Faint text]	
81. SIGNATURE OF DECEASED [Faint text]		82. SIGNATURE OF DECEASED [Faint text]	
83. SIGNATURE OF DECEASED [Faint text]		84. SIGNATURE OF DECEASED [Faint text]	
85. SIGNATURE OF DECEASED [Faint text]		86. SIGNATURE OF DECEASED [Faint text]	
87. SIGNATURE OF DECEASED [Faint text]		88. SIGNATURE OF DECEASED [Faint text]	
89. SIGNATURE OF DECEASED [Faint text]		90. SIGNATURE OF DECEASED [Faint text]	
91. SIGNATURE OF DECEASED [Faint text]		92. SIGNATURE OF DECEASED [Faint text]	
93. SIGNATURE OF DECEASED [Faint text]		94. SIGNATURE OF DECEASED [Faint text]	
95. SIGNATURE OF DECEASED [Faint text]		96. SIGNATURE OF DECEASED [Faint text]	
97. SIGNATURE OF DECEASED [Faint text]		98. SIGNATURE OF DECEASED [Faint text]	
99. SIGNATURE OF DECEASED [Faint text]		100. SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

MAR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete this certificate has been signed by the attending physician and complete this certificate. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete this certificate. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3053

## CERTIFICATE OF DEATH

02999

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>79 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo Heights</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>				d. STREET ADDRESS <b>5319 Tuscawawas Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alan</b> Middle <b>Scott</b> Last <b>Dinsmore</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 14, 1951</b>	
9. AGE (In years lost birthday) <b>4</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>1</b> Hours <b>56</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Egypt</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lee F. Dinsmore</b>				14. MOTHER'S MAIDEN NAME <b>Millie Perkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>The Medical Record, The Clinical Center</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia (Pseudomonas)</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphatic Leukemia</b> DUE TO (c) <b>15 months</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec. 19</b> , 19 <b>55</b> , to <b>March 7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 7</b> , 19 <b>56</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center, NIH, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner Jr. M.D.</b>				DATE SIGNED <b>3/7/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>3/8/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. S. P. Harris Co.</b>				ADDRESS <b>2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-9-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

274-05

720

August 11, 1951

6124

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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Filr G191 1-2-56 et

3054

## CERTIFICATE OF DEATH

03000

Reg. Dist. No. 218

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u> c. LENGTH OF STAY IN b. <u>1 Year</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Gaithersburg</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <u>MAUDE</u> Middle <u>A</u> Last <u>DORSEY</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>8</u> Year <u>1956</u>					
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>col</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12, 1884</u> <u>SEPT 18, 1884</u>		<b>9. AGE</b> (In years lost birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>John H Riggs</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Frazier</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT</b> <u>Matthew Darry Gaithersburg</u> Address <u>  </u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Nephritis without edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertension</u> (c) <u>Cardiorenal Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Epilepsy Petto Mal</u>								<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 days</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no</u>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>		<b>20f. (City or town)</b> <u>  </u> (County) <u>  </u> (State) <u>  </u>			
<b>21. I certify that I attended the deceased from</b> <u>May 17, 1948</u> , to <u>March 8, 1956</u> , that I last saw the deceased alive on <u>March 7, 1956</u> , and that death occurred at <u>6:15 A.M.</u> , from the causes and on the date stated above. <b>ACTUAL SIGNATURE</b> <u>Webster Sewell</u> M.D. <u>Norbeck Rt 1 Silver Spring</u> <b>PHYSICIAN'S NAME (Type)</b> <u>WEBSTER SEWELL</u> <u>3.9.56</u>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>Mar 10 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Brook Grove Md</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Lafayette</u> (State) <u>MD</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Roy W. Barber</u> ADDRESS <u>Lafayette</u>				<b>24a. REC'D BY REGISTRAR</b> <u>Abuda G. Cooke</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

206

Name of Deceased		Sex	
Age		Date of Birth	
Place of Birth		Usual Residence	
Cause of Death		Date of Death	
Time of Death		Place of Death	
Signature of Physician		Signature of Registrar	

Chronic Interstitial Nephritis  
with  
Hypertension

March 17, 1936

March 17, 1936

BUREAU V. 2

MAR 26 1936

RECEIVED

RECEIVED  
March 17, 1936  
Bureau of Vital Statistics  
State of Massachusetts

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 12 Film G195 4-12-56 et  
3055  
CERTIFICATE OF DEATH

03001

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory Grove Gaithersburg</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>La Kerne</u> Middle <u>Elizabeth</u> Last <u>Duwall</u>		4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1 1941</u>
9. AGE (In years lost birthday) <u>14</u> yrs.		10. IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>school</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alfred Duwall</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Neal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Eleanor Neal</u>		Address <u>Gaithersburg, Md. Route # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anaphylaxis</u> <u>490X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Penicillin &amp; Streptomycin</u> (c) <u>Bilateral Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. s. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 8, 1954</u> to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u>		ADDRESS (Street, city or town, state) <u>Norbeck Rd, Silver Spring, Md.</u>	
DATE SIGNED <u>3/25/56</u>		DATE SIGNED <u>3/25/56</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>Mar 28/56</u>		24b. REGISTRAR'S SIGNATURE <u>Abner L. Cook</u>	

BUREAU V. 3

APR 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03002

2991

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>6 hr-10 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>8914 Walden Rd</u>			
3. NAME OF DECEASED (Type or print) <u>LAWRENCE</u> <u>L.</u> <u>Dyer</u>				4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-08</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GREENE &amp; DYER, INC.</u>		11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hiram H. Dyer</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Staley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>2</u>		17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, acute</u> DUE TO <u>Coronary occlusion</u> (b) <u>Coronary arteriosclerosis</u> DUE TO <u>Coronary arteriosclerosis</u> (c) <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>@ 8 HRS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>54</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-18-</u> , 19 <u>56</u> , and that death occurred at <u>2:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Bernard A. Fitzgerald</u> M.D.				ADDRESS (Street, city or town, state) <u>9620 Old Bladensburg Rd</u>		DATE SIGNED <u>3/19/56</u>	
PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				<u>Silver Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/22/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PARKLAWN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, aw. SS. Md</u> ADDRESS <u>8434 Ga.</u>				24a. REC'D BY REGISTRAR <u>3/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. H. Doherty</u>	

BUREAU V. S.

MAR 21 1956

RECEIVED

**THE UNIVERSITY OF CHICAGO**



2992

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 56			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanatorium - Hospital</u>				d. STREET ADDRESS <u>1211 Dale Drive</u> 1			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William HENRY DYRE</u>				4. DATE OF DEATH Month Day Year <u>MARCH 25 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/31/91</u>		9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Internal Revenue</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>JAMES W DYRE</u>				14. MOTHER'S MAIDEN NAME <u>LAURA ZEIGLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes World War I</u>		16. SOCIAL SECURITY NO. <u>53-0070-157</u>		17. INFORMANT Address <u>Mrs. Laura M. Dyre 1211 Dale Dr. S.S., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443x DUE TO <u>Hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis Generalized</u> (c) <u>10 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17 hrs</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr 25</u> , 19 <u>56</u> , to <u>25 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 March</u> , 19 <u>56</u> , and that death occurred at <u>7:35</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>M. B. Queen</u> M.D.				ADDRESS (Street, city or town, state) <u>7112 Willow Ave</u>		DATE SIGNED <u>25 May 56</u>	
PHYSICIAN'S NAME (Type) <u>M. B. Queen</u>				<u>Takoma Park Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRICE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey</u>				ADDRESS <u>8434 Ga Ave SSM</u>		24a. REC'D BY REGISTRAR <u>DATE 3/27/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. M. Dealt</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF CLERGYMAN		19. SIGNATURE OF MINISTER		20. SIGNATURE OF CHAPLAIN	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF CHAPLAIN		23. SIGNATURE OF CLERGYMAN		24. SIGNATURE OF NEXT OF KIN		25. SIGNATURE OF DECEASED	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF NEXT OF KIN		28. SIGNATURE OF CLERGYMAN		29. SIGNATURE OF MINISTER		30. SIGNATURE OF CHAPLAIN	
31. SIGNATURE OF CHAPLAIN		32. SIGNATURE OF CLERGYMAN		33. SIGNATURE OF MINISTER		34. SIGNATURE OF NEXT OF KIN		35. SIGNATURE OF DECEASED	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF NEXT OF KIN		38. SIGNATURE OF CLERGYMAN		39. SIGNATURE OF MINISTER		40. SIGNATURE OF CHAPLAIN	
41. SIGNATURE OF CHAPLAIN		42. SIGNATURE OF CLERGYMAN		43. SIGNATURE OF MINISTER		44. SIGNATURE OF NEXT OF KIN		45. SIGNATURE OF DECEASED	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF NEXT OF KIN		48. SIGNATURE OF CLERGYMAN		49. SIGNATURE OF MINISTER		50. SIGNATURE OF CHAPLAIN	
51. SIGNATURE OF CHAPLAIN		52. SIGNATURE OF CLERGYMAN		53. SIGNATURE OF MINISTER		54. SIGNATURE OF NEXT OF KIN		55. SIGNATURE OF DECEASED	
56. SIGNATURE OF DECEASED		57. SIGNATURE OF NEXT OF KIN		58. SIGNATURE OF CLERGYMAN		59. SIGNATURE OF MINISTER		60. SIGNATURE OF CHAPLAIN	
61. SIGNATURE OF CHAPLAIN		62. SIGNATURE OF CLERGYMAN		63. SIGNATURE OF MINISTER		64. SIGNATURE OF NEXT OF KIN		65. SIGNATURE OF DECEASED	
66. SIGNATURE OF DECEASED		67. SIGNATURE OF NEXT OF KIN		68. SIGNATURE OF CLERGYMAN		69. SIGNATURE OF MINISTER		70. SIGNATURE OF CHAPLAIN	
71. SIGNATURE OF CHAPLAIN		72. SIGNATURE OF CLERGYMAN		73. SIGNATURE OF MINISTER		74. SIGNATURE OF NEXT OF KIN		75. SIGNATURE OF DECEASED	
76. SIGNATURE OF DECEASED		77. SIGNATURE OF NEXT OF KIN		78. SIGNATURE OF CLERGYMAN		79. SIGNATURE OF MINISTER		80. SIGNATURE OF CHAPLAIN	
81. SIGNATURE OF CHAPLAIN		82. SIGNATURE OF CLERGYMAN		83. SIGNATURE OF MINISTER		84. SIGNATURE OF NEXT OF KIN		85. SIGNATURE OF DECEASED	
86. SIGNATURE OF DECEASED		87. SIGNATURE OF NEXT OF KIN		88. SIGNATURE OF CLERGYMAN		89. SIGNATURE OF MINISTER		90. SIGNATURE OF CHAPLAIN	
91. SIGNATURE OF CHAPLAIN		92. SIGNATURE OF CLERGYMAN		93. SIGNATURE OF MINISTER		94. SIGNATURE OF NEXT OF KIN		95. SIGNATURE OF DECEASED	
96. SIGNATURE OF DECEASED		97. SIGNATURE OF NEXT OF KIN		98. SIGNATURE OF CLERGYMAN		99. SIGNATURE OF MINISTER		100. SIGNATURE OF CHAPLAIN	

BUREAU V. 8

APR 2 1956

RECEIVED

3056

CERTIFICATE OF DEATH

03004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rural-Rockville, Md. (Manor Club)</u>				d. STREET ADDRESS <u>Rural-Rockville, Md. (Manor Club)</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN WILLIAM EBERT</u>				4. DATE OF DEATH Month Day Year <u>March 10, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mch 22, 1871</u>	9. AGE (In years last birthday) yrs. <u>84</u>	IF UNDER 1 YEAR Months Days <u>11 18</u>	IF UNDER 24 HRS. Hours Min. <u>11 18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Ebert</u>				14. MOTHER'S MAIDEN NAME <u>Emma E. Stanley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Jerney Ebert-Item# 2</u>		17. INFORMANT Address <u>Jerney Ebert-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Myocarditis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>July</u> , 19 <u>51</u> , to <u>March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 9</u> , 19 <u>56</u> , and that death occurred at <u>1:00 A.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>D. Bonifant</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Sandy Spring Md 3/10/56</u>			
PHYSICIAN'S NAME (Type) <u>D. Bonifant Sandy Spring, Maryland</u>				<u>3/10/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/12/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>M. R. Etchison Funeral Home Frederick, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>3/12/56</u>	24b. REGISTRAR'S SIGNATURE <u>Lawell H. Bryant</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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21/12/1901. James & Robert.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03005

3057

## CERTIFICATE OF DEATH

Reg. Dist. No.

210

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>		c. LENGTH OF STAY IN TB <b>3 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>60 11,602 IDLEWOOD ROAD</b>		e. STREET ADDRESS <b>11,602 IDLEWOOD ROAD</b>	
3. NAME OF DECEASED (Type or print) First <b>ROSA</b> Middle <b>BELLE</b> Last <b>EDWARDS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>15</b> Year <b>1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 27, 1873</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN HENRY EDWARDS</b>	
14. MOTHER'S MAIDEN NAME <b>SARAH unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. RANDOLPH C. EDWARDS, 11602 IDLEWOOD ROAD SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Secondary Anemia</b> DUE TO (c) <b>Cancer of Cecum</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease, Chronic Glomerulonephritis</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>14 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 1, 1954</b> , to <b>March 15, 1956</b> , that I last saw the deceased alive on <b>Feb. 28, 1956</b> , and that death occurred at <b>4:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Russell B. Arnold</b>		ADDRESS (Street, city or town, state) <b>8801 Coleville Road, Silver Spring, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Russell B. Arnold M.D.</b>		DATE SIGNED <b>March 15, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/17/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BURTONSVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner &amp; Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3/16/56</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>	



60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. After this certificate has been signed by the attending physician and completed, it shall be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03006

3058

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alexander John Eisenrauch</u>		4. DATE OF DEATH <u>March 28</u> 19 <u>56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1885</u>
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>15</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2 woodworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoreham Hotel</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolph Eisenrauch</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-2419</u>	
17. INFORMANT <u>Wife, Louise Eisenrauch above</u>		Address <u>above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>611 X Pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1112c Thrombosis</u> DUE TO (c) <u>Suprapubic prostatectomy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 min</u> <u>2-3 d.</u> <u>8 ✓</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> 19 <u>56</u> p. m. <u>—</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/18</u> , 19 <u>56</u> , to <u>3/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>56</u> , and that death occurred at <u>10:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Umhoe</u>		ADDRESS (Street, city or town, state) <u>8805 Conn. Ave.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Umhoe</u>		DATE SIGNED <u>3/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>2-30-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

# CERTIFICATE OF DEATH

3082

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

Reg. Dist. No.

NAME OF DECEASED		DATE OF BIRTH		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1892		JAN 15 1956	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH	
BALTIMORE, MARYLAND		LABORER		HEART DISEASE	
MARRIAGE		EDUCATION		MANNER OF DEATH	
MARRIED		HIGH SCHOOL		NATURAL	
COLOR		RELIGION		PLACE OF DEATH	
WHITE		METHODIST		HOME	
SEX		AGE		TIME OF DEATH	
MALE		64		10:30 AM	
TEMPERATURE		PULSE		RESPIRATIONS	
98.6		72		16	
BLOOD PRESSURE		WEIGHT		HEIGHT	
120/80		170		5' 10"	
SPECIAL INSTRUCTIONS		SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
		J. H. HARRIS		J. H. HARRIS	

BUREAU V. S.

APR 3 1956

RECEIVED

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS AND THE PHYSICIAN WHO ATTENDED THE DECEASED. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON. IT IS NOT VALID IF SIGNED BY THE REGISTRAR OF DEATHS AND THE PHYSICIAN WHO ATTENDED THE DECEASED. IT IS NOT VALID IF SIGNED BY ANY OTHER PERSON.

3059

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>22 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>4325 East West Highway</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William J. Ellison</u>		4. DATE OF DEATH <u>March 29 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-97</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Architect</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>New York</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Ellison</u>		14. MOTHER'S MAIDEN NAME <u>N. Judd</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>579-18-8894</u>	
17. INFORMANT <u>Constance M. Ellison</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Mar 29 1956</u> to <u>March 29 1956</u> that I last saw the deceased alive on <u>March 29 1956</u> , and that death occurred at <u>10:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Gray Jr.</u>		DATE SIGNED <u>3/29/56</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray Jr.</u>		ADDRESS <u>104 Cherry Chase Dr</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md</u>	
24a. REC'D BY REGISTRAR <u>4-2-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

APR 4 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03008

3060

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5206 Chandler Road</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5206 Chandler Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ARNOLD C. ENGEL, SR.</b>				4. DATE OF DEATH Month <b>March</b> , Day <b>30</b> , Year <b>1956</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-13-1890</b>	
9. AGE (In years last birthday) yrs. <b>65</b>		IF UNDER 1 YEAR Months <b>4</b> , Days <b>0</b> , Hours <b>0</b> , Min. <b>0</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Acct.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington, D. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Wm. A Engel</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Scherite</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WW 1</b>				16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Arnold C. Engel, Jr. - Item # 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart Failure</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Coronary Arterial Vascular Disease</b> DUE TO <b>Hypertensive Heart Disease</b> (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>7 wks.</b> <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 Mar. 1953</b> to <b>30 Mar. 1956</b> , that I last saw the deceased alive on <b>25 Mar. 1956</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>30 Mar 56</b> DATE SIGNED ACTUAL SIGNATURE <b>Warren Burch</b> M.D. PHYSICIAN'S NAME (Type) <b>Warren Burch 4220 - 45th. St., N.W. Washington, D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda Md.</b>		24a. REC'D BY REGISTRAR <b>4-2-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

RECEIVED

APR 4 1956

BUREAU V. 2

MARILAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10	
3000	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED HARRISON	
2. SEX Male	
3. AGE 3200	
4. DATE OF DEATH March 30, 1956	
5. PLACE OF DEATH 3200 Chandler Road	
6. CAUSE OF DEATH C. ENDO, 31. - 1956	
7. PLACE OF BIRTH USA	
8. DATE OF BIRTH March 30, 1924	
9. PLACE OF BIRTH USA	
10. SIGNATURE OF DECEASED HARRISON	
11. SIGNATURE OF WITNESS HARRISON	
12. SIGNATURE OF DECEASED HARRISON	
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99. SIGNATURE OF WITNESS HARRISON	
100. SIGNATURE OF DECEASED HARRISON	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
3061  
CERTIFICATE OF DEATH

03009

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 Oak Street</u>				d. STREET ADDRESS <u>10 Oak Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>Laura</u> Last <u>Fairall</u>				4. DATE OF DEATH Month <u>March</u> Day <u>21</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-1868</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>A. F. Fairall</u>				14. MOTHER'S MAIDEN NAME <u>E. Woods</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Merton F. Duvall</u> Address <u>10 Oak St. Gaith. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 17, 1956</u> , to <u>March 21, 1956</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Luciano I. Leal</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>				<u>112 N Frederick Ave.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Mar 28/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Abner H. Cooke</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
**CERTIFICATE OF DEATH**  
 13001

PLACE OF BIRTH [Faint text]		SEX [Faint text]	
DATE OF BIRTH [Faint text]		AGE [Faint text]	
PLACE OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
PLACE OF INTERMENT [Faint text]		NAME OF FUNERAL HOME [Faint text]	
NAME OF DECEASED [Faint text]		NAME OF NEXT OF KIN [Faint text]	
ADDRESS OF DECEASED [Faint text]		ADDRESS OF NEXT OF KIN [Faint text]	
OCCUPATION OF DECEASED [Faint text]		OCCUPATION OF NEXT OF KIN [Faint text]	
MARITAL STATUS [Faint text]		EDUCATION [Faint text]	
PREVIOUS ILLNESS [Faint text]		MEDICAL HISTORY [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF NEXT OF KIN [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF FUNERAL HOME [Faint text]	
DATE [Faint text]		TIME [Faint text]	

**RECEIVED**  
 APR 4 1956  
**BUREAU V. 8**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3062 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03010

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Montg.</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda R-3</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda R-3</b> <span style="float: right;"><b>X</b></span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Falls Rd.</b>				d. STREET ADDRESS <b>Falls Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Wilbert Fairfax</b> <div style="text-align: center;">First Middle Last</div>				4. DATE OF DEATH <b>March 24</b> 19 <b>56</b> <div style="text-align: center;">Month Day Year</div>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>ool</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/21/1902</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>cement finisher</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Fairfax</b>				14. MOTHER'S MAIDEN NAME <b>Julia Gamby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Velvet Fairfax, Bethesda, Md.</b> <div style="text-align: right;">Address</div>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>History of previous attacks</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Frank J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>3/25/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn,</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Swarden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>2-29-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



APR 3 1956

03011

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 214

3063

1. PLACE OF DEATH- COUNTY <u>Montg</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salmon Spring</u> TOWN <u>Salmon Spring</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2401 Pine Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Montg</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salmon Spring</u> TOWN <u>Salmon Spring</u> STREET ADDRESS (If rural, give location) <u>8507 Old Bleeding Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Fort</u> (Last)		4. DATE OF DEATH <u>Mar</u> (Month) <u>5</u> (Day) <u>1956</u> (Year)	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>12-15-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nut Vendor</u>	9. AGE last birthday <u>69</u> yrs. <input checked="" type="checkbox"/> If under 1 year Months <u>5</u> Days <u>5</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Prussia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT AND ADDRESS <u>Mrs Samia Fort (wife) Same as dec'd</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420. Immediate cause (a) <u>Coronary occlusion</u>			<u>sudden</u>
Antecedent cause(s) (b) <u>---</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>---</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 7, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>King David Memorial Cemetery, Falls Church, Virginia</u>	LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
DATE REC'D BY LOCAL REG. <u>3-5-56</u>		REGISTRAR'S SIGNATURE <u>Francis Potter</u>		24. FUNERAL DIRECTOR ADDRESS <u>13 Maryland Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 218

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>monty</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>201 Lee St</u>		LENGTH OF STAY (in this place) <u>3 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Gaithersburg</u>				STREET ADDRESS (If rural, give location) <u>201 Lee St</u>			
3. NAME OF DECEASED: (First) <u>Brosch</u>		(Middle) <u>Joan</u>		(Last) <u>Franklin</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>mar 11 19 56</u>	
5. SEX <u>fe</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept 9 - 1926</u>		9. AGE last birthday: <u>29</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>housework</u>		11. BIRTHPLACE (State or foreign country): <u>San Diego Calif</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Albert Mattoon</u>				14. MOTHER'S MAIDEN NAME: <u>Carlean Bismore</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Norman S. Franklin Gaithersburg 201 Forest</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
Immediate cause <u>3533</u>		(a) <u>Asphyxia due to laryngeal spasm</u>					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(b) <u>aspiration of blood due to laceration of tongue</u>					
		(c) <u>fall following epileptic seizure</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>encephalitis several yrs ago</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosch</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-11-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>		LOCATION (City, town, or county) (State) <u>Gaithersburg md</u>	
DATE REC'D BY LOCAL REG. <u>Mar 13, 1956</u>		REGISTRAR'S SIGNATURE <u>Abraham H. [illegible]</u>		24. FUNERAL DIRECTOR <u>Ernest C. Gaithersburg Gaithersburg</u> ADDRESS <u>road</u>			

MAR 16 1956

RECEIVED

BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03013**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>L. Geo</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <span style="float: right;"><u>16-15-2</u></span> d. STREET ADDRESS <u>1703 Crosby Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Melville Frank Freas, Jr.</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>March 31 19 56</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 30, 1917</u>		<b>9. AGE</b> (In years last birthday) <u>38</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Accounting</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Conn.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Melville Frank Freas, Sr.</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>May Shaw</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/>		<b>16. SOCIAL SECURITY NO.</b> <u>March '42-'45</u>		<b>17. INFORMANT</b> <u>Father</u>		<b>Address</b> <u>  </u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr.</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , <b>Accident</b> <input type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined cause</b> <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u> <b>EXAMINER'S NAME (Type)</b> <u>Frank J Broschart</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Removal</u>				<b>22b. DATE THEREOF</b> <u>4/1/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Northwood Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> (State) <u>Philadelphia Pa.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The S.H. Hines Co. 2901-14th st. N.W.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>4/3/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. Hines</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1  
 BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
MANNER OF DEATH		CAUSE OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POST-MORTEM	
SIGNATURE OF EXAMINER		DATE		TIME		PLACE		HOURS		MINUTES	
SIGNATURE OF WITNESS		DATE		TIME		PLACE		HOURS		MINUTES	

RECEIVED  
 APR 5 1955  
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3965

CERTIFICATE OF DEATH

Reg. Dist. No.

03014  
274

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Kensington Gardens Nursing Home</u>		d. STREET ADDRESS <u>5930-13<sup>th</sup> Place N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last <u>FRIEDMAN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>11<sup>th</sup></u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<u>Retired (Painter)</u>		<u>House painter</u>	<u>Russia</u>
13. FATHER'S NAME <u>Harry Friedman</u>		14. MOTHER'S MAIDEN NAME <u>Zlota Lipson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Sam Jeweler Wash. D.C.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis (CVA)</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>over 1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<u>9069 FRACTURE LEFT HIP (Closed Reduction) 2 mos ago</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
		20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>February, 1955</u> , to <u>March 10, 1956</u> , that I last saw the deceased alive on <u>March 10<sup>th</sup>, 1956</u> , and that death occurred at <u>3:35 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Samuel Dove</u>		ADDRESS (Street, city or town, state) <u>1801 Eye St. N.W.</u> DATE SIGNED <u>3/11/56</u>	
PHYSICIAN'S NAME (Type) <u>SAMUEL DOVE</u>		<u>Washington 6, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 13, 1956</u>	<u>MT. Hebron Cemetery</u>	<u>Maspeth, L.I.N.Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
<u>B. Danyausky</u>		<u>3501-14 St NW</u>	<u>DATE 13 1956 Mrs. Frances Potters</u>

CERTIFICATE OF DEATH

3000

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. PLACE OF BIRTH <i>Baltimore, Md.</i>		6. DATE OF BIRTH <i>Jan 15, 1910</i>	
7. PLACE OF DEATH <i>Home</i>		8. DATE OF DEATH <i>Mar 10, 1956</i>	
9. CAUSE OF DEATH <i>Heart Disease</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. K. Smith</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>Dr. J. K. Smith</i>		14. SIGNATURE OF DECEASED <i>John Doe</i>	
15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF DECEASED <i>John Doe</i>		20. SIGNATURE OF DECEASED <i>John Doe</i>	
21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>	
25. SIGNATURE OF DECEASED <i>John Doe</i>		26. SIGNATURE OF DECEASED <i>John Doe</i>	
27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>	
31. SIGNATURE OF DECEASED <i>John Doe</i>		32. SIGNATURE OF DECEASED <i>John Doe</i>	
33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>	
37. SIGNATURE OF DECEASED <i>John Doe</i>		38. SIGNATURE OF DECEASED <i>John Doe</i>	
39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>	
43. SIGNATURE OF DECEASED <i>John Doe</i>		44. SIGNATURE OF DECEASED <i>John Doe</i>	
45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>	
49. SIGNATURE OF DECEASED <i>John Doe</i>		50. SIGNATURE OF DECEASED <i>John Doe</i>	
51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>	
55. SIGNATURE OF DECEASED <i>John Doe</i>		56. SIGNATURE OF DECEASED <i>John Doe</i>	
57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>	
61. SIGNATURE OF DECEASED <i>John Doe</i>		62. SIGNATURE OF DECEASED <i>John Doe</i>	
63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>	
67. SIGNATURE OF DECEASED <i>John Doe</i>		68. SIGNATURE OF DECEASED <i>John Doe</i>	
69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>	
73. SIGNATURE OF DECEASED <i>John Doe</i>		74. SIGNATURE OF DECEASED <i>John Doe</i>	
75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>	
79. SIGNATURE OF DECEASED <i>John Doe</i>		80. SIGNATURE OF DECEASED <i>John Doe</i>	
81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>	
85. SIGNATURE OF DECEASED <i>John Doe</i>		86. SIGNATURE OF DECEASED <i>John Doe</i>	
87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>	
91. SIGNATURE OF DECEASED <i>John Doe</i>		92. SIGNATURE OF DECEASED <i>John Doe</i>	
93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>	
97. SIGNATURE OF DECEASED <i>John Doe</i>		98. SIGNATURE OF DECEASED <i>John Doe</i>	
99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

RECEIVED  
MAR 13 1956  
BUREAU V. 2

# CERTIFICATE OF DEATH

Item 6, Film G193 3-12-56 et

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (When deceased lived. If infirm: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington San Hosp.</u>		c. LENGTH OF STAY IN 1b <u>42 1/2 hrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Max</u> Middle <u>O</u> Last <u>Futrowsky</u>		4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-9-03</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dry cleaning Bus</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Dry cleaning</u>	
12. BIRTHPLACE (State or foreign country) <u>Europe-Russia</u>		13. CITIZEN OF WHAT COUNTRY? <u>America</u>	
14. FATHER'S NAME <u>Isaac Futrowsky</u>		15. MOTHER'S MAIDEN NAME <u>Lemkovitch</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		17. SOCIAL SECURITY NO. <u>5-78-03-2529</u>	
18. INFORMATION <u>Washington San Hosp. Records</u>		19. ADDRESS <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>  </u> years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Hemorrhage - 48 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
21a. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>  </u> <u>19</u>		21b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		22b. (City or town) (County) (State) <u>  </u>	
23. I certify that I attended the deceased from <u>Feb 29, 1956</u> to <u>March 4, 1956</u> that I last saw the deceased alive on <u>3-4-56</u> 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul Canet</u>		DATE SIGNED <u>6-7-56</u>	
PHYSICIAN'S NAME (Type) <u>PAUL CANET</u>		M.D. <u>6727-16th St. N.E.</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE THEREOF <u>3/6/56</u>	
24c. NAME OF CEMETERY OR CREMATORY <u>Westcap Hl.</u>		24d. LOCATION (City, town, or county) (State) <u>Wash DC</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis &amp; Son</u>		25a. REC'D BY REGISTRAR DATE <u>3-6-56</u>	
ADDRESS <u>Wash 10 St</u>		25b. REGISTRAR'S SIGNATURE <u>J. Wilson Add</u>	

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3066

## CERTIFICATE OF DEATH

03016

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Washington, D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - S. S., Md.</u>				c. LENGTH OF STAY IN 1b <u>5 yrs. 5 mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Cedarcroft Sanitarium and Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D. C.</u>			
				d. STREET ADDRESS <u>5210 Nahant Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Lawrence</u> Last <u>Gardiner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>19 56</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 22, 1880</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Daingerfield Lawrence</u>				14. MOTHER'S MAIDEN NAME <u>Margaretta La. Ford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-05-8509D</u>		17. INFORMANT <u>Lawrence Gardiner</u> Address <u>Blauvelt N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac coronary Occlusion</u> <u>334X</u> DUE TO <u>Cachexia due to cerebral arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>with psychosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>54</u> , to <u>March 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>6:20P M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Abner J. Kistler</u> M.D.				ADDRESS (Street, city or town, state) <u>Cedar Croft San Hosp Silver Spring Md</u>			
PHYSICIAN'S NAME (Type) <u>A. J. Kistler, M. D.</u>				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APR 2 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EMMANUEL Church</u>		22d. LOCATION (City, town, or county) (State) <u>Glencoe Balto Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. H. Hinkins &amp; Sons Co</u>				ADDRESS <u>4905 YORK Rd</u>		24a. REC'D BY REGISTRAR <u>APR 3 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Patten</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3067

## CERTIFICATE OF DEATH

Reg. Dist. No.

03017

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>New York</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>33 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		d. STREET ADDRESS <b>31 Paul Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Norine</b> Last <b>Gardner</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1927</b>
9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Frank Burgess</b>		14. MOTHER'S MAIDEN NAME <b>Mildred Watt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>539-18-2100</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema and congestive cardiac failure</b> <b>195X</b> DUE TO <b>Adrenal cortical carcinoma metastatic to liver</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>lungs and spine</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 2, 1956</b> , to <b>March 6, 1956</b> , that I last saw the deceased alive on <b>March 6, 1956</b> , and that death occurred at <b>6:20 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Herbert Lubs</b> <b>The Clinical Center, NIH, Bethesda, Md.</b> <b>3/7/56</b>			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Herbert Lubs, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Transit 3-7-56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Freemont</b>		22d. LOCATION (City, town, or county) (State) <b>Stuben Co., New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>3-8-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

CERTIFICATE OF DEATH

DATE OF DEATH April 14, 1967		PLACE OF DEATH The Clinical Center	
DECEASED Male		AGE 37 days	
MARRIAGE Never Married		OCCUPATION Infant	
BIRTH April 14, 1967		BIRTH PLACE Washington	
FATHER John A. A.		MOTHER Mary A. A.	
CAUSE OF DEATH Sudden Infant Death Syndrome		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN [Signature]		SIGNATURE OF REGISTRAR [Signature]	
DATE April 14, 1967		TIME 10:00 AM	
PLACE The Clinical Center, Bethesda, Maryland		COUNTY Montgomery	

BUREAU V. S.

MAR 12 1966

RECEIVED



3068

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <b>DIST. OF COLUMBIA</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>2701 14th St., N.W.</b>			
3. NAME OF DECEASED (Type or print) <b>Gertrude Ann GEARY</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1 October 1878</b>	
				9. AGE (In years last birthday) <b>77 7/8</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
13. FATHER'S NAME <b>Charles A. CLISHAM</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann FARMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>(Son) Daniel J. GEARY, 1758 N. Troy St., Arlington, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary atherosclerosis</b> DUE TO (c) <b>Generalized atherosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>6:00 AM</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>19 Feb.</b> 19 <b>56</b> to <b>20 March</b> 19 <b>56</b> , that I last saw the deceased alive on <b>20 March</b> 19 <b>56</b> , and that death occurred at <b>6:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Schlang</b>				DATE SIGNED <b>3-20-56</b>			
PHYSICIAN'S NAME (Type) <b>H. A. SCHLANG, CDR, MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 Mar 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.L. Farrar</b>				ADDRESS <b>2901 14th St N.W. Washington, D.C.</b>		24a. REC'D BY REGISTRAR <b>3-20-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Danally</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



3069

CERTIFICATE OF DEATH

03019

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ches.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, - (Rural)</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MAE</b> Middle <b>EIDSON</b> Last <b>GILBERT</b>				4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 October 1919</b>		9. AGE (In years last birthday) <b>36</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Service</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Walter M. COLLINS</b>				14. MOTHER'S MAIDEN NAME <b>Lilly Mae Eidson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Village, Indian Head, Md. (Husband) Wendlin G. GILBERT, 24 "H" Riverside</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hemorrhagic pancreatitis</b> - less than 1 week DUE TO <b>Laennec's cirrhosis</b> unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Disorders, psychotic due to physical etiology (toxic delirium)</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>14 March</b> , 19 <b>56</b> , to <b>20 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>20 March</b> , 19 <b>56</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>McAllison, Jr.</b>				M.D. <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>M. E. ALLISON JR LT, MC, USN</b>				<b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-23-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Dorham Episcopal Cemetery Ironside, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, La Plata, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 3-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>	

CERTIFICATE OF DEATH

3052

NAME OF DECEASED WILLIAM		DATE OF DEATH 1950	
SEX Male		AGE 60	
RACE White		EDUCATION High School	
OCCUPATION Carpenter		RESIDENCE 1234 Main St, Baltimore, Md	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
PLACE OF DEATH Home		DATE OF BURIAL 1950	
NAME OF FUNERAL HOME ABC Funeral Home		NAME OF MINISTER John Doe	
NAME OF NEXT OF KIN John Doe		NAME OF PHYSICIAN Dr. Smith	
NAME OF CORONER John Doe		NAME OF JURY John Doe	
NAME OF STATE ATTORNEY John Doe		NAME OF DISTRICT ATTORNEY John Doe	
NAME OF COUNTY ATTORNEY John Doe		NAME OF CITY ATTORNEY John Doe	
NAME OF TOWNSHIP ATTORNEY John Doe		NAME OF VILLAGE ATTORNEY John Doe	
NAME OF WARD ATTORNEY John Doe		NAME OF PRESTBYTERY ATTORNEY John Doe	
NAME OF PARISH ATTORNEY John Doe		NAME OF CONGREGATION ATTORNEY John Doe	
NAME OF SYNAGOGUE ATTORNEY John Doe		NAME OF CHURCH ATTORNEY John Doe	
NAME OF MOSQUE ATTORNEY John Doe		NAME OF TEMPLE ATTORNEY John Doe	
NAME OF OTHER ATTORNEY John Doe		NAME OF OTHER ATTORNEY John Doe	

RECEIVED  
MAR 25 1950  
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3070

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03020

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8110 Georgetown Road</u>		d. STREET ADDRESS <u>8110 Georgetown Road</u>	
3. NAME OF DECEASED (Type or print) First <u>JESS</u> Middle <u>SPANGLER</u> Last <u>GILL</u>		4. DATE OF DEATH Month <u>March</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1880</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>13</u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Spangler</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Elizabeth Rebuck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-01-6946</u>	
17. INFORMANT <u>Mrs. Ruth A. Gill Berger-Daughter</u>		Address <u>Bethesda, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>4 years</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Obstructive ileus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>52</u> , to <u>March 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>56</u> , and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. Roger Kurtz</u> M.D.		DATE SIGNED <u>3-20-56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Roger Kurtz</u>		<u>3701 Conn. Ave. N.W. Wash. D.C. 3-20-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-24-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>3-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	





## CERTIFICATE OF DEATH

Reg. Dist. No. 216

3971

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7807 Exeter Rd.</u>		d. STREET ADDRESS <u>7807 Exeter Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Eustace Straughn Glascock</u>		4. DATE OF DEATH Month Day Year <u>March 13, 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/63</u>
9. AGE (In years last birthday) <u>92</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired patent attorney</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gloucester, Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>Gloucester, Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Luther Glascock</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Maria</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Elizabeth G. Taylor</u>		Address <u>daughter</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiplegia, left, acute</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalised</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs.</u> <u>5 yrs +</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Aug. 1954</u> , to <u>March 13, 1956</u> , that I last saw the deceased alive on <u>March 12, 1956</u> , and that death occurred at <u>4:30 a.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		M.D. <u>3921 Ingomar St. NW Wash DC</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>		DATE SIGNED <u>3-13-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>3/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets Church Cem. Annapolis, Md.</u>	22d. LOCATION (City, town, or county) (State) <u>(State)</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Jones Co.</u>		ADDRESS <u>2901 14th St. N.W.</u>	24a. REC'D BY REGISTRAR <u>DATE 8-14-56</u>
		24b. REGISTRAR'S SIGNATURE <u>Bennie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. DATE OF BIRTH May 19, 1921	
5. PLACE OF BIRTH Jackson, Mississippi		6. OCCUPATION Minister		7. MARITAL STATUS Single		8. COLOR White	
9. PLACE OF DEATH Memphis, Tennessee		10. CAUSE OF DEATH Gunshot wound		11. MANNER OF DEATH Suicide		12. DATE OF DEATH April 4, 1968	
13. SIGNATURE OF DECEASED James Earl Ray		14. SIGNATURE OF WITNESS John Edgar Hoover		15. SIGNATURE OF PHYSICIAN John Edgar Hoover		16. SIGNATURE OF CORONER John Edgar Hoover	
17. SIGNATURE OF DECEASED James Earl Ray		18. SIGNATURE OF WITNESS John Edgar Hoover		19. SIGNATURE OF PHYSICIAN John Edgar Hoover		20. SIGNATURE OF CORONER John Edgar Hoover	
21. SIGNATURE OF DECEASED James Earl Ray		22. SIGNATURE OF WITNESS John Edgar Hoover		23. SIGNATURE OF PHYSICIAN John Edgar Hoover		24. SIGNATURE OF CORONER John Edgar Hoover	
25. SIGNATURE OF DECEASED James Earl Ray		26. SIGNATURE OF WITNESS John Edgar Hoover		27. SIGNATURE OF PHYSICIAN John Edgar Hoover		28. SIGNATURE OF CORONER John Edgar Hoover	
29. SIGNATURE OF DECEASED James Earl Ray		30. SIGNATURE OF WITNESS John Edgar Hoover		31. SIGNATURE OF PHYSICIAN John Edgar Hoover		32. SIGNATURE OF CORONER John Edgar Hoover	
33. SIGNATURE OF DECEASED James Earl Ray		34. SIGNATURE OF WITNESS John Edgar Hoover		35. SIGNATURE OF PHYSICIAN John Edgar Hoover		36. SIGNATURE OF CORONER John Edgar Hoover	
37. SIGNATURE OF DECEASED James Earl Ray		38. SIGNATURE OF WITNESS John Edgar Hoover		39. SIGNATURE OF PHYSICIAN John Edgar Hoover		40. SIGNATURE OF CORONER John Edgar Hoover	
41. SIGNATURE OF DECEASED James Earl Ray		42. SIGNATURE OF WITNESS John Edgar Hoover		43. SIGNATURE OF PHYSICIAN John Edgar Hoover		44. SIGNATURE OF CORONER John Edgar Hoover	
45. SIGNATURE OF DECEASED James Earl Ray		46. SIGNATURE OF WITNESS John Edgar Hoover		47. SIGNATURE OF PHYSICIAN John Edgar Hoover		48. SIGNATURE OF CORONER John Edgar Hoover	
49. SIGNATURE OF DECEASED James Earl Ray		50. SIGNATURE OF WITNESS John Edgar Hoover		51. SIGNATURE OF PHYSICIAN John Edgar Hoover		52. SIGNATURE OF CORONER John Edgar Hoover	
53. SIGNATURE OF DECEASED James Earl Ray		54. SIGNATURE OF WITNESS John Edgar Hoover		55. SIGNATURE OF PHYSICIAN John Edgar Hoover		56. SIGNATURE OF CORONER John Edgar Hoover	
57. SIGNATURE OF DECEASED James Earl Ray		58. SIGNATURE OF WITNESS John Edgar Hoover		59. SIGNATURE OF PHYSICIAN John Edgar Hoover		60. SIGNATURE OF CORONER John Edgar Hoover	
61. SIGNATURE OF DECEASED James Earl Ray		62. SIGNATURE OF WITNESS John Edgar Hoover		63. SIGNATURE OF PHYSICIAN John Edgar Hoover		64. SIGNATURE OF CORONER John Edgar Hoover	
65. SIGNATURE OF DECEASED James Earl Ray		66. SIGNATURE OF WITNESS John Edgar Hoover		67. SIGNATURE OF PHYSICIAN John Edgar Hoover		68. SIGNATURE OF CORONER John Edgar Hoover	
69. SIGNATURE OF DECEASED James Earl Ray		70. SIGNATURE OF WITNESS John Edgar Hoover		71. SIGNATURE OF PHYSICIAN John Edgar Hoover		72. SIGNATURE OF CORONER John Edgar Hoover	
73. SIGNATURE OF DECEASED James Earl Ray		74. SIGNATURE OF WITNESS John Edgar Hoover		75. SIGNATURE OF PHYSICIAN John Edgar Hoover		76. SIGNATURE OF CORONER John Edgar Hoover	
77. SIGNATURE OF DECEASED James Earl Ray		78. SIGNATURE OF WITNESS John Edgar Hoover		79. SIGNATURE OF PHYSICIAN John Edgar Hoover		80. SIGNATURE OF CORONER John Edgar Hoover	
81. SIGNATURE OF DECEASED James Earl Ray		82. SIGNATURE OF WITNESS John Edgar Hoover		83. SIGNATURE OF PHYSICIAN John Edgar Hoover		84. SIGNATURE OF CORONER John Edgar Hoover	
85. SIGNATURE OF DECEASED James Earl Ray		86. SIGNATURE OF WITNESS John Edgar Hoover		87. SIGNATURE OF PHYSICIAN John Edgar Hoover		88. SIGNATURE OF CORONER John Edgar Hoover	
89. SIGNATURE OF DECEASED James Earl Ray		90. SIGNATURE OF WITNESS John Edgar Hoover		91. SIGNATURE OF PHYSICIAN John Edgar Hoover		92. SIGNATURE OF CORONER John Edgar Hoover	
93. SIGNATURE OF DECEASED James Earl Ray		94. SIGNATURE OF WITNESS John Edgar Hoover		95. SIGNATURE OF PHYSICIAN John Edgar Hoover		96. SIGNATURE OF CORONER John Edgar Hoover	
97. SIGNATURE OF DECEASED James Earl Ray		98. SIGNATURE OF WITNESS John Edgar Hoover		99. SIGNATURE OF PHYSICIAN John Edgar Hoover		100. SIGNATURE OF CORONER John Edgar Hoover	

RECEIVED  
MAR 16 1968  
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3072

## CERTIFICATE OF DEATH

03022

Reg. Dist. No. 214

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Dist. Of Col.</b> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>				d. STREET ADDRESS <b>1210- Mass. Ave. N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>LLOYD</b> Middle <b>H.</b> Last <b>GOODE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 10, 1880</b>		9. AGE (In years last birthday) <b>75</b> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Cashier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parking Bus.</b>		11. BIRTHPLACE (State or foreign country) <b>Cleveland County, No. Caro.</b>			
13. FATHER'S NAME <b>Julius M. Goode</b>			14. MOTHER'S MAIDEN NAME <b>Laura Frances Warlick</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT <b>Mrs. Elmer Shane, Sis. - 1210- Mass. Ave. N.W., D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Rectum with Metastases</b> 154X DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____ (c) DUE TO _____				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Heart Disease</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>2 Jan. 1956</b> to <b>8 March 56</b> , that I last saw the deceased alive on <b>8 March 56</b> , and that death occurred at <b>7:54 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert C. Haile</b>		DATE SIGNED <b>35 New York Ave. N.W. 11 March 56</b>					
PHYSICIAN'S NAME (Type) <b>Robert C. Haile, M.D., 35- New York Ave. N.W., Washington, D.C.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR. 13/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM.</b>			
22d. LOCATION (City, town, or county) _____ (State) _____		<b>PRINCE GEO. COUNTY, MD.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson Co.</b>			ADDRESS <b>1300-N ST. N.W. D.C.</b>				
24a. REC'D BY REGISTRAR <b>3/15/56</b>			24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>				

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3073

## CERTIFICATE OF DEATH

03023

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Louisiana</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN lb <b>50 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baton Rouge</b> <b>56x.3</b> ✓			
d. STREET ADDRESS <b>1409 Daniel Webster</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Warren</b> Middle <b>James</b> Last <b>Green, Jr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>September 15, 1953</b>		9. AGE (In years last birthday) yrs. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren Green</b>				14. MOTHER'S MAIDEN NAME <b>Frances Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2040 Acute Lymphocytic Leukemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 18, 1956</b> , to <b>March 8, 1956</b> , that I last saw the deceased alive on <b>March 8, 1956</b> , and that death occurred at <b>5:05 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Claude E. Forkner, Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center, NIH, Bethesda, Md.</b> DATE SIGNED <b>3/8/56</b>			
PHYSICIAN'S NAME (Type) <b>Claude E. Forkner, Jr., M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frazier Frazier/Hom</b>				ADDRESS <b>389 R.I. Ave. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>3-9-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>			

CERTIFICATE OF DEATH

DECEASED NAME JAMES EARL RAY		SEX Male		AGE 35 years		DATE OF DEATH September 11, 1968		PLACE OF DEATH Baltimore	
RESIDENCE 1000 ...		OCCUPATION ...		CAUSE OF DEATH ...		MANNER OF DEATH ...		SIGNATURE OF DECEASED ...	
SIGNATURE OF PHYSICIAN ...		SIGNATURE OF MEDICAL EXAMINER ...		SIGNATURE OF ... ...		SIGNATURE OF ... ...		SIGNATURE OF ... ...	
SIGNATURE OF ... ...		SIGNATURE OF ... ...		SIGNATURE OF ... ...		SIGNATURE OF ... ...		SIGNATURE OF ... ...	

BUREAU V. 3

MAR 13 1968

RECEIVED

3074

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> - MARYLAND		CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>Olney</u> -		STATE <u>MD.</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Olney</u> -	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sharon Chronic Hospital</u>		LENGTH OF STAY (in this place) <u>8-8-54</u>		STREET ADDRESS (If rural give location) <u>Sharon Chronic Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Julia A. Hardesty</u>				<u>March 13 1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W-</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>Sept. 29, 1867</u>	9. AGE last birthday: <u>88</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Washington - D.C.</u>	
13. FATHER'S NAME: <u>Thomas M. Harrey</u>				14. MOTHER'S MAIDEN NAME: <u>Julia H. Adams -</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR FOREST (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. William Amos, Spencerville Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Femoral artery occlusion (left)</u>						3 day	
ANTECEDENT CAUSE (S) (B) <u>Gen. art. Sclerosis - Diabetes</u>						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Myelitis acute</u>						20 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>12 8, 1954</u> to <u>3-13, 1956</u> that I last saw the deceased alive on <u>10 March, 1956</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John Booley Ziegler</u> M.D.				ADDRESS <u>Olney, Md.</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>March 16 56</u>		<u>Fort Lincoln</u>		<u>Was in</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-56</u>		REGISTRAR'S SIGNATURE <u>Eustace B. Lawler</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber</u>		ADDRESS <u>Spencerville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 19 1956

RECEIVED

3075

03025

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

No. 214

## 1. PLACE OF DEATH:

COUNTY **MONTGOMERY** MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **SILVER SPRING**  
 TOWN **SILVER SPRING** LENGTH OF STAY (in this place) **Since 1947**

HOSPITAL OR INSTITUTION OR STREET ADDRESS **8317 DRAPER LANE**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **MARYLAND** COUNTY **MONTGOMERY**  
 CITY (If outside corporate limits write RURAL and give nearest town) **SILVER SPRING**  
 TOWN **SILVER SPRING**

STREET ADDRESS **8317 DRAPER LANE** (If rural, give location)

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

5. SEX: **MALE**6. COLOR OR RACE: **WHITE**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **SINGLE**8. DATE OF BIRTH: **7/24/88**

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

**Mar 20****1956**9. AGE last birthday: **67** yrs.IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS.  
Hours Min.10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): **Clerical**10b. KIND OF BUSINESS OR INDUSTRY: **Wash. Gas Light Co.**11. BIRTHPLACE (State or foreign country): **Washington, D. C.**12. CITIZEN OF WHAT COUNTRY? **U.S.A.**13. FATHER'S NAME: **Staff Asst. WILLIAM F. HART**14. MOTHER'S MAIDEN NAME: **HELEN A. STEPHENS**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) **NO** (If Yes, give war or dates of service)16. SOCIAL SECURITY No.: **577-07-7548**17. INFORMANT & ADDRESS: **Mrs. Leonard J. Leland, 3101 18th St., N.W. Washington, D. C.**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

**Sudden**

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

**Frank J. Brochert**CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
DEPUTY MEDICAL EXAMINER ☒  
M. D. ASSISTANT MEDICAL EXAM. ☒ **3-20-56**

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

**3/24/56** **Francis Potter** **Walter C. Humphrey** **Silver Spring, Md.**



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3019

## CERTIFICATE OF DEATH

03026

Reg. Dist. No. 213

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>26 Rockville,</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 240 N. Washington Street.,</u>		d. STREET ADDRESS <u>240 N. Washington Street.,</u>	
3. NAME OF DECEASED (Type or print) <u>Margaret Elizabeth Hartman</u>		4. DATE OF DEATH Month <u>March</u> Day <u>26,</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1892</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Charwoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>	
11. BIRTHPLACE (State or foreign country) <u>Rockville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Wesley Carroll</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Norris</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret A. Browne.</u>		Address <u>Rockville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C. R. Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>  </u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 10, 1949</u> to <u>March 26, 1956</u> , that I last saw the deceased alive on <u>March 25, 1956</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Webster Sewell</u> M.D.		ADDRESS (Street, city or town, state) <u>Norbeck Rd Silver Spring</u>	
PHYSICIAN'S NAME (Type) <u>WEBSTER SEWELL, M.D.</u>		DATE SIGNED <u>3/29/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/29/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park,</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 4/2/56</u>		24b. REGISTRAR'S SIGNATURE <u>Louise H. Singler</u>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03027

3076

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Silver Spring</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Silver Spring</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1608 Moffet Road</u>				STREET ADDRESS (If rural give location) <u>1608 Moffet Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY FRANCES HARTUNG</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>3-17-1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>married</u>		8. DATE OF BIRTH <u>July 23, 1877</u>	
				9. AGE last birthday <u>78</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>David Coberth</u>				14. MOTHER'S MAIDEN NAME <u>Unobtainable</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>1608 Moffett Rd. Harry B. Hartung-Silver Spring, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
1. IMMEDIATE CAUSE (A) <u>ACUTE CONGESTIVE CARDIAC FAILURE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>						?	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTENSION</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		<u>none</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-21-1955</u> , to <u>3-17-1956</u> , that I last saw the deceased alive on <u>3-16-1956</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Leo J. Schildhaus</u>				ADDRESS (Street, city, town, state) <u>6101 New Hampshire Ave Washington D.C.</u> DATE SIGNED <u>3/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/20/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Prince Georges Co., Md.</u>	
24. REC'D BY REGISTRAR <u>3-19-56</u>		REGISTRAR'S SIGNATURE <u>Frances Potter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Wines Company</u> ADDRESS			

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write)

John Henry Jones  
 1000 North Street  
 Silver Spring  
 1928 North Street

2. Sex  
 Male

3. Date of birth

4. Place of birth

5. Date of death

6. Time of death

7. Day, month, year

8. Cause of death

9. Nature of disease

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of church

15. Name of school

16. Name of hospital

17. Name of nursing home

18. Name of prison

19. Name of other institution

20. Name of other place

21. Name of other place

22. Name of other place

23. Name of other place

24. Name of other place

25. Name of other place

26. Name of other place

27. Name of other place

28. Name of other place

29. Name of other place

30. Name of other place

31. Name of other place

32. Name of other place

33. Name of other place

34. Name of other place

35. Name of other place

BUREAU V. S.

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NOTIFICATION

1. Name of informant  
 2. Address of informant  
 3. Date of notification  
 4. Signature of informant  
 5. Signature of registrar  
 6. Signature of physician  
 7. Signature of funeral director  
 8. Signature of undertaker  
 9. Signature of cemetery  
 10. Signature of church  
 11. Signature of school  
 12. Signature of hospital  
 13. Signature of nursing home  
 14. Signature of prison  
 15. Signature of other institution  
 16. Signature of other place



03028

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3077

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>MONTGOMERY</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Montgomery</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>SILVER SPRING</b>		<b>Feb. 1, 1952</b>		TOWN <b>Silver Spring</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Maple Lane Nursing Home</b>				<b>9810 Georgia Avenue</b>			
3. NAME OF DECEASED: (Type or Print)		(First) <b>MARY</b>		(Middle) <b>E</b>		(Last) <b>HEIL</b>	
4. DATE OF DEATH:		(Month) <b>MARCH</b>		(Day) <b>4</b>		(Year) <b>1956</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>female</b>	<b>white</b>	<b>widowed</b>	<b>March 11, 1879</b>	<b>76</b> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<b>Housewife - Own home</b>					<b>Washington, D. C.</b>		<b>U.S.A.</b>
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Robert Montgomery</b>				<b>Anna Mac Laney</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>no</b>		<b>none</b>		<b>Mrs. Thomas M. Jenkins, 8708 Susanna Lane North Chevy Chase, Md.</b>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>HYPERTENSIVE HEART DISEASE</b>							
DUE TO							
ANTECEDENT CAUSE (B) <b>ESSENTIAL HYPERTENSION</b>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <b>GENERALIZED ARTERIOSCLEROSIS</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>SENILITY</b>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>2-1</b> 19 <b>52</b> to <b>3-4</b> 19 <b>56</b> that I last saw the deceased alive on <b>3-4</b> 19 <b>56</b> and that death occurred at <b>9:28 p.m.</b> M, from the causes and on the date stated above.							
SIGNATURE		M. D.		ADDRESS		DATE SIGNED	
<b>Frances Toller</b>		<b>5296 Norway Ave</b>		<b>3/4/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>3/7/56</b>		<b>Arlington Nat'l. Cemetery</b>		<b>Arlington, Virginia</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>3-6-56</b>		<b>Frances Toller</b>		<b>Warner E. Pumphrey</b>		<b>8434 Ga. Ave. Silver Spring, Md.</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MAR 9 1956

BUREAU V. S.

3078

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b> <b>National Institutes of Health</b>				d. STREET ADDRESS <b>3543 Hertford Place, N. W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Myer</b> Middle <b>(None)</b> Last <b>Herman</b>				4. DATE OF DEATH Month <b>March</b> Day <b>10</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 17, 1885</b>	
9. AGE (In years last birthday) yrs. <b>70</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Myer Herman</b>			
14. MOTHER'S MAIDEN NAME <b>Miriam Slotnikov</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>The medical record, The Clinical Center</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma, primary bronchiogenic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>NONE</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 7, 1955</b> , to <b>March 10, 1956</b> , that I last saw the deceased alive on <b>March 10, 1956</b> , and that death occurred at <b>1:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lester M. Cramer, M.D.</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda, Maryland</b>			
DATE SIGNED <b>3/10/56</b>				PHYSICIAN'S NAME (Type) <b>Lester M. Cramer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Mar 11/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Antebellum</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Danzansky &amp; Son</b>				ADDRESS <b>3501-14th St NW</b>		24a. REC'D BY REGISTRAR DATE <b>3-21-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completed, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



03030

MARYLAND

STATE DEPARTMENT OF HEALTH

3079

## CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH- COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>District of Columbia</i> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Silver Spring</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>47x-3</i>	
TOWN <i>4 months</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Glenside Nursing Home 2012 Old Bladensburg Rd.</i>		STREET ADDRESS (If rural, give location) <i>1341 Adams St. N.E.</i>	
3. NAME OF DECEASED (Type or Print) <i>Elizabeth</i> (First) <i>K.</i> (Middle) <i>Hollidge</i> (Last)		4. DATE OF DEATH (Month) <i>3</i> (Day) <i>17</i> (Year) <i>1956</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>3/26/1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housekeeper</i>	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <i>72</i> yrs.	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Cyrus Keiser</i>	14. MOTHER'S MAIDEN NAME <i>Elizabeth H. Sweeten</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If year, give war or dates of service)	16. SOCIAL SECURITY No. <i>578-44-5106</i>	17. INFORMANT AND ADDRESS <i>Thomas Hollidge - 1341 Adams St. N.E. Wash. D.C.</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause <i>Generalized Carcinomatosis</i>		<i>1 month</i>
(b) Antecedent cause(s) <i>Carcinoma of colon</i>		<i>4 years</i>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS <i>Malnutrition</i>		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov. 22, 1956*, to *March 17, 1956*, that I last saw the deceased alive on *March 6, 1956*, and that death occurred at *10:45 p.m.*, from the causes and on the date stated above.

SIGNATURE *Erica Mager, M.D.* ADDRESS *8401 University Lane, Silver Spring, Md.* DATE SIGNED *3/17/56*

23. BURIAL, CREMATION REMOVAL (Specify) *Removal* DATE *3-18-56* NAME OF CEMETERY OR CREMATORY *Washington D.C.* LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. *3-19-56* REGISTRAR'S SIGNATURE *Francis Potter* 24. FUNERAL DIRECTOR *J. H. Lee & Sons, Wash. D.C.* ADDRESS

MARGIN RESERVED FOR BINDING



BUREAU V. S.

MAR 21 1955

RECEIVED

3080  
CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH a. COUNTY <b>Montg,</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montg,</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boyd's</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Lester</b> Middle <b>House</b> Last		4. DATE OF DEATH Month <b>Mar</b> Day <b>25</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan 28-1889</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>25</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Penn.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>William H. House</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah G. Sevingle</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Edith M. Joerg</b> Address <b>Silverspring</b> <b>11504 Galt Ave. Gaithersburg</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>5261</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Lung Abscess.</b> DUE TO (c) <b>Bronchitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 minutes</b> <b>2 years</b> <b>6 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1 Dec.</b> , 19 <b>54</b> , to <b>23 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>23 March</b> , 19 <b>56</b> , and that death occurred at <b>10:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John G. Lawrence</b> M.D.		ADDRESS (Street, city or town, state) <b>Boyd, Md</b> DATE SIGNED <b>24 March 56</b>	
PHYSICIAN'S NAME (Type) <b>JOHN G. LAWRENCE</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-26-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ines Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Coudersport Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest C. Gartner.</b>		ADDRESS <b>Gaithersburg Md,</b>	
24a. REC'D BY REGISTRAR DATE <b>Mar 27/56</b>		24b. REGISTRAR'S SIGNATURE <b>Abner L. Cooke</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF DECEASED		15. SIGNATURE OF FUNERAL HOME	
16. SIGNATURE OF CHURCH		17. SIGNATURE OF BURIAL PLACE		18. SIGNATURE OF INTERMENT	
19. SIGNATURE OF CREMATION		20. SIGNATURE OF REINTERMENT		21. SIGNATURE OF REINTERMENT	
22. SIGNATURE OF REINTERMENT		23. SIGNATURE OF REINTERMENT		24. SIGNATURE OF REINTERMENT	
25. SIGNATURE OF REINTERMENT		26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT	
28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT	
34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT		36. SIGNATURE OF REINTERMENT	
37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT	
40. SIGNATURE OF REINTERMENT		41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT	
43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT	
49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT		51. SIGNATURE OF REINTERMENT	
52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT	
55. SIGNATURE OF REINTERMENT		56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT	
58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT	
64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT		66. SIGNATURE OF REINTERMENT	
67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT	
70. SIGNATURE OF REINTERMENT		71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT	
73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT	
79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT		81. SIGNATURE OF REINTERMENT	
82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT	
85. SIGNATURE OF REINTERMENT		86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT	
88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT	
94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT		96. SIGNATURE OF REINTERMENT	
97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT	
100. SIGNATURE OF REINTERMENT		101. SIGNATURE OF REINTERMENT		102. SIGNATURE OF REINTERMENT	

RECEIVED  
APR 4 1956  
BUREAU V. B.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2995 CERTIFICATE OF DEATH

03032

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>24 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>7637 Carroll Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Cora</u> First <u>Ann</u> Middle <u>Hudson</u> Last				<b>4. DATE OF DEATH</b> <u>3</u> - <u>5</u> - <u>1956</u>			
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>12-12-80</u>	
<b>9. AGE</b> (In years last birthday) <u>75</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Griffin F. Marks</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alpha D. Bowls</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Washington San. and Hospital Records</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442x Hypertensive heart disease</u> DUE TO (b) <u>congestive failure</u> DUE TO (c) <u>renal insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>20 yrs</u> <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>		<b>21. I certify that I attended the deceased from</b> <u>1948</u> , 19 <u>  </u> , to <u>3-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-4</u> , 19 <u>56</u> , and that death occurred at <u>1:02</u> M., from the causes and on the date stated above.	
<b>ACTUAL SIGNATURE</b> <u>E. W. Woloshin</u> M.D.				<b>ADDRESS</b> (Street, city or town, state) <u>508 Underwood St. N.W.</u>			
<b>PHYSICIAN'S NAME</b> (Type) <u>Chas H. Woloshin</u>				<b>DATE SIGNED</b> <u>3-5-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>MAR 7, 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>GEORGE WASHINGTON CEM. REGS. RD. R. Geo Geo</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>MD.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>G. Arthur Walker</u> ADDRESS <u>254 Carroll St. N.W. Wash. D.C.</u>				<b>24a. REC'D BY REGISTRAR</b> <u>3-5-56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur Dodd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. Certificate has been signed by the attending physician and completed in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3781

## CERTIFICATE OF DEATH

Reg. Dist. No.

03033

266

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CHEVY CHASE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CHEVY CHASE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Late residence</b>		d. STREET ADDRESS <b>25 LA VELLE</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLE</b> Middle <b>ORR</b> Last <b>HUNTINGTON</b>		4. DATE OF DEATH Month <b>3</b> Day <b>27</b> Year <b>1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-23-84</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>SALEM OHIO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>CHARLES ORR</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SNYDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>DR. MARGARET H. SLOAN</b> Address <b>25 LA VELLE DR</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BREAST CA METASTATIC TO LUNG</b> <b>170X</b> DUE TO <b>BONE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC LYMPHATIC LEUKEMIA</b> DUE TO (c) <b>CHRONIC LYMPHATIC LEUKEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>2:15</b> P. M. <b>3-27</b> 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-1</b> , 1956, to <b>3-27</b> , 1956, that I last saw the deceased alive on <b>3-20</b> , 1956, and that death occurred at <b>2:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard H. Ostrow</b> M.D.		ADDRESS (Street, city or town, state) <b>7961 Eastern Ave</b>	
PHYSICIAN'S NAME (Type) <b>BERNARD H. OSTROW</b>		DATE SIGNED <b>3/27/1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/27/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b> ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE 3-28-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH 4/4/68	
PLACE OF DEATH MEMPHIS, TENNESSEE		AGE 35	
SEX MALE		RACE WHITE	
OCCUPATION CONGRESSMAN		EDUCATION HIGH SCHOOL	
MANNER OF DEATH SUICIDE		CAUSE OF DEATH FIRE	
PLACE OF BIRTH MOBILE, ALABAMA		DATE OF BIRTH 1/5/33	
MOTHER'S NAME MAE A. RAY		FATHER'S NAME JAMES EARL RAY	
MARRIAGE MARRIED		SPOUSE'S NAME JANE PAULINE RAY	
PREVIOUS MARRIAGES NONE		PREVIOUS SPOUSES NONE	
RELIGION METHODIST		BAPTISM YES	
EDUCATION HIGH SCHOOL		OCCUPATION CONGRESSMAN	
MANNER OF DEATH SUICIDE		CAUSE OF DEATH FIRE	
PLACE OF BIRTH MOBILE, ALABAMA		DATE OF BIRTH 1/5/33	
MOTHER'S NAME MAE A. RAY		FATHER'S NAME JAMES EARL RAY	
MARRIAGE MARRIED		SPOUSE'S NAME JANE PAULINE RAY	
PREVIOUS MARRIAGES NONE		PREVIOUS SPOUSES NONE	
RELIGION METHODIST		BAPTISM YES	
EDUCATION HIGH SCHOOL		OCCUPATION CONGRESSMAN	

RECEIVED  
BUREAU V. S.  
MAR 29 1956

Robert A. Humphrey  
Baltimore, Maryland  
3/27/1956  
Cecil Hill Cemetery  
Baltimore, Maryland

3082

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>Rt. #3</u>	
3. NAME OF DECEASED (Type or print) First <u>SALLIE</u> Middle <u>Viola</u> Last <u>IMES</u>		4. DATE OF DEATH Month <u>2</u> - Day <u>11</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-99</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JERRY Diggs</u>		14. MOTHER'S MAIDEN NAME <u>Ada</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Katherine Dyson - daughter</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Exemia, and Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chronic nephritis, type undetermined</u> DUE TO <u>Unknown</u> (c) <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-13-56</u> , 19 <u>56</u> , to <u>3-11-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-10-56</u> , 19 <u>56</u> , and that death occurred at <u>5:15 AM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Suburban Hospital, Bethesda, Md.</u>	
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.		DATE SIGNED <u>3/12/56</u>	
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Poplar Grove,</u>		22d. LOCATION (City, town, or county) (State) <u>Poplar Grove, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Williams - Poplar Rd</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>3-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Form fields for death certificate including: Name, Sex, Age, Race, Date of Birth, Date of Death, Place of Death, Cause of Death, and Signature.

*Handwritten text:*  
The deceased was a male, white, aged 68 years, who died on March 23, 1956, at his home, 1234 Main Street, Baltimore, Maryland. The cause of death was listed as "Heart Disease." The death was certified by Dr. J. A. Smith, M.D., of the Baltimore City Health Department.

*Handwritten text:*  
BUREAU V. S.  
MAR 23 1956  
RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

3083

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>36 minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL Laurel</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital</b>				d. STREET ADDRESS <b>Rt. #2, Box 84</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Effie</b> Middle <b>Melinda</b> Last <b>Jackson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/8/92</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Lee</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Hospital Record</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Descending Aneurysm of Aorta</b> DUE TO <b>Essential Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>No injury</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>never</b> , 19____, to <b>7 March</b> , 19 <b>56</b> , and that death occurred at <b>5:45 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis A. Craig, Jr.</b>				ADDRESS (Street, city or town, state) <b>1801 K ST. N.W., Wash. D.C.</b>			
PHYSICIAN'S NAME (Type) <b>Louis A. Craig, Jr.</b>				DATE SIGNED <b>8 Mar 56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/10/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Round Oak</b>		22d. LOCATION (City, town, or county) (State) <b>Spencerville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b>				ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-10-56</b>	
						24b. REGISTRAR'S SIGNATURE <b>Esther B. Fowler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 9, Film 193 3-12-56 et  
3084  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

03036  
214

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kensington Gardens Mont. Co. Nursing Home MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D.C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Kensington, Md.		c. LENGTH OF STAY IN 1b 3 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3000 McComas Ave. Kensington Gardens Nursing Home				d. STREET ADDRESS 5424 MacArthur Blvd., N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fannie Middle L. Last Jackson				4. DATE OF DEATH Month March 1, Day 1956 Year 19			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/5/1876	
9. AGE (In years last birthday) 86 7/8 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) D.C.	
13. FATHER'S NAME unobtainable				14. MOTHER'S MAIDEN NAME unobtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Maude Bartoo 5424 MacArthur Blvd. Wash, D.C.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral hemorrhage (c) Cerebral arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 72 hours 10 days 15 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 9, 1956, to 1 MAR, 1956, that I last saw the deceased alive on 1 MAR, 1956, and that death occurred at M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles W. Thompson M.D.				ADDRESS (Street, city or town, state) DATE SIGNED 1714 - N. W. WASH. D.C.			
PHYSICIAN'S NAME (Type) CHARLES W. THOMPSON M.D.							
22a. BURIAL OR CREMATION REMOVAL (Specify)		22b. DATE THEREOF 3/2/56		22c. NAME OF CEMETERY OR CREMATORY Sharon Cemetery		22d. LOCATION (City, town, or county) (State) Hillsboro, N.C.	
23. FUNERAL DIRECTOR'S SIGNATURE The S. H. Hines Co.				ADDRESS Wash, D.C. 2901 14th St. N.W.		24a. REC'D BY REGISTRAR DATE 3/5/56	
				24b. REGISTRAR'S SIGNATURE Francis Potter			

MEDICAL CERTIFICATION

RECEIVED

MAR 7 1956

BUREAU V. S.

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 3085 CERTIFICATE OF DEATH

03037

Reg. Dist. No. 214

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY MONTGOMERY	MARYLAND	STATE MARYLAND	COUNTY MONTGOMERY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING	LENGTH OF STAY (in this place) 14 yrs.	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN SILVER SPRING	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 734 EASLEY ST.		STREET ADDRESS (If rural give location) 734 EASLEY STREET	
3. NAME OF DECEASED (Type or Print) MARY McENEANEY JACOBS		4. DATE OF DEATH MARCH 4 1956	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 1, 1868
9. AGE last birthday 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE - retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) IRELAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OWEN McENEANEY		14. MOTHER'S MAIDEN NAME BRIDGETT H. DUFFY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS Mrs. J. Frank Hushion, 734 Easley St. Silver Spring, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis		8 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 4/11/47, 1947, to 3/4, 1956, that I last saw the deceased alive on 3/4, 1956, and that death occurred at 1:00 P.M. from the causes and on the date stated above.			
SIGNATURE 107320 W androp		ADDRESS (Street, city, town, state) 837 Bonifant St. SILVER SPRING, MD.	
DATE SIGNED 3/4/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) TRANS. & BURIAL		DATE THEREOF 3/8/56	
NAME OF CEMETERY OR CREMATORY HOLY CROSS CEMETERY		LOCATION (City, town, or county) YEADON, PENNSYLVANIA	
24. REC'D BY REGISTRAR DATE 3/7/56		REGISTRAR'S SIGNATURE Francis Peter Warner & Humphrey	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS SILVER SPRING, MD.			

# DEATH CERTIFICATE

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. PLACE OF INTERMENT

12. DATE OF INTERMENT

13. NAME OF FUNERAL HOME

14. NAME OF MINISTER

15. NAME OF CHURCH

16. NAME OF CEMETERY

17. NAME OF BURIAL

18. NAME OF COFFIN

19. NAME OF CASK

20. NAME OF CASK

21. NAME OF CASK

22. NAME OF CASK

23. NAME OF CASK

24. NAME OF CASK

25. NAME OF CASK

26. NAME OF CASK

27. NAME OF CASK

28. NAME OF CASK

29. NAME OF CASK

30. NAME OF CASK

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is moved from the place of death. It should be filled out in the presence of the family, and the signature of the physician or other qualified person should be witnessed by two other persons who are not members of the family. The certificate should be filed with the local health officer, and a copy should be sent to the State Department of Health. The certificate is valid for one year from the date of death.

BUREAU V. E.

MAR 12 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03038

2996

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>16 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>75 Washington Sanitarium + Hosp</u>				d. STREET ADDRESS <u>8815-Briarley Rd</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Richard Edwin Johnson</u>				4. DATE OF DEATH Month Day Year <u>March 29 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1898</u> <del>XXXXXXXXXXXX</del>	9. AGE (In years last birthday) <u>57</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Landscape gardening</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Oliver G. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Ida J. Custer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT Address <u>Sarah A. Johnson-Item# 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>540.1</u> IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>perforated peptic ulcer of stomach</u> DUE TO (c) <u>peptic ulcer - essential hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>19 March</u> , 19 <u>56</u> , to <u>29 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 March</u> , 19 <u>56</u> , and that death occurred at <u>5:20 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>John M. Wyman</u>				M.D. <u>7659 Georgetown Rd</u> <u>30 March 56</u>			
PHYSICIAN'S NAME (Type) <u>John M. Wyman M.D.</u>				<u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-2-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u>		22d. LOCATION (City, town, or county) (State) <u>Beallsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>				ADDRESS <u>7557 W. Ave. Bethesda</u>		24a. REC'D BY REGISTRAR <u>J. Wilson</u> DATE <u>3/31/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed in by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

681-2264

103 7. Carter

Oliver G. Johnson

2011-10-10

BUREAU V. S.

APR 3 1956

RECEIVED

3086

## CERTIFICATE OF DEATH

03039

Reg. Dist. No.

274

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>va</u> b. COUNTY <u>Warwick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hilton Village</u> 83 X - 3 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Kensington Gardens Nursing</u>				d. STREET ADDRESS <u>301 Paige Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>A D A</u> Middle <u>C</u> Last <u>KRAUSE</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10/1890</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Store Keeper self</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Jacob D Krause</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address: <u>Jacob D Krause Riverdale, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 yrs</u> <u>15 yrs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>Nov 19 19</u>				20d. INJURY OCCURRED <u>While at work</u> <input checked="" type="checkbox"/> <u>Not while at work</u> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>October, 1955</u> to <u>March, 1956</u> , that I last saw the deceased alive on <u>1 March, 1956</u> , and that death occurred at <u>3057</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Morton L. White</u> M.D.				ADDRESS (Street, city or town, state) <u>11134 Georgia Ave S.S. Md</u>			
DATE SIGNED <u>March 4, 1956</u>							
PHYSICIAN'S NAME (Type) <u>Morton L. White</u>							
22a. BURIAL, CREMATION, REMOVAL <u>Transportation</u>		22b. DATE THEREOF <u>3/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dunport near me</u>		22d. LOCATION (City, town, or county) (State) <u>me</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. Garcke Sons Hyattsville Md</u>				24a. REC'D BY REGISTRAR <u>Francis Potter</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF BIRTH		DATE OF DEATH	
MAY 10 1892		MAY 10 1956	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
MARRIED		MARRIED	
YES		YES	
NAME OF SPOUSE		NAME OF SPOUSE	
JANE D. [illegible]		JANE D. [illegible]	
DATE OF MARRIAGE		DATE OF MARRIAGE	
[illegible]		[illegible]	
CAUSE OF DEATH		CAUSE OF DEATH	
[illegible]		[illegible]	
MANNER OF DEATH		MANNER OF DEATH	
[illegible]		[illegible]	
OCCUPATION		OCCUPATION	
[illegible]		[illegible]	
EDUCATION		EDUCATION	
[illegible]		[illegible]	
RELIGION		RELIGION	
[illegible]		[illegible]	
SIGATURE OF DECEASED		SIGATURE OF DECEASED	
[illegible]		[illegible]	
SIGATURE OF WITNESS		SIGATURE OF WITNESS	
[illegible]		[illegible]	
SIGATURE OF PHYSICIAN		SIGATURE OF PHYSICIAN	
[illegible]		[illegible]	
DATE OF SIGNATURE		DATE OF SIGNATURE	
[illegible]		[illegible]	

BUREAU V. S.

MAR 6 1956

RECEIVED

Handwritten notes and signatures at the bottom of the page.

2997

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>4 wks. 6 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>			
d. STREET ADDRESS <u>1437 Whittier St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Loula</u> First <u>Lampiris</u> Middle Last				4. DATE OF DEATH <u>March 27 1956</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-16</u>	
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>America</u>							
13. FATHER'S NAME <u>Gus Picoulas</u>				14. MOTHER'S MAIDEN NAME <u>Katherine -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Medical Records - Washington San. &amp; Hosp.</u> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> 401.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Perforation of Uleer of the Sigmoid</u> (c) <u>Pericarditis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Scleroderma - 8+ years.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>2 1/2 days.</u> <u>2 wks.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.				20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/22/1956</u> , to <u>3/27/1956</u> , that I last saw the deceased alive on <u>March 27 1956</u> , and that death occurred at <u>9:50 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Hare M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Robert A. HARE, M.D.</u>				DATE SIGNED			
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>3-29-56</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>	
22d. LOCATION (City, town, or county) <u>Washington</u> (State) <u>DC</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Real Funeral Home</u> ADDRESS <u>4817 W. Ave N.W. Washington, D.C.</u>				24a. REC'D BY REGISTRAR <u>3/31/56</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur Bell</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



APR 3 1956

RECEIVED

3087 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5209 Rayland Drive</b>		d. STREET ADDRESS <b>5209 Rayland Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>RYENZA</b> Middle <b>SCOTT</b> Last <b>LANGLEY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-1895</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>28</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Gov. Vet. Adm. Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Robert W. Scott</b>	
14. MOTHER'S MAIDEN NAME <b>Anna V. Yancey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Ione S. Ebrite - Sister</b> Address <b>Bethesda Md 5209 Rayland Dr</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-respir. failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma</b> DUE TO (c) <b>Adenocarcinoma of colon</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>1 1/2 yrs</b> <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I attended the deceased from <b>June 1, 1952</b> , to <b>3/2/56</b> , that I last saw the deceased alive on <b>3/2/56</b> , and that death occurred at <b>5:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stephen N. Jones</b>		ADDRESS (Street, city or town, state) <b>809 Viers Mill Rd. Rockville Maryland</b>	
PHYSICIAN'S NAME (Type) <b>STEPHEN N. JONES, M.D.</b>		DATE SIGNED <b>3/3/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-6-1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bessie M. Thompson</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		DATE OF DEATH	
AT HOME		MAY 19 1936	
DECEASED'S NAME		BIRTH OF DECEASED	
JOHN J. BROWN		MAY 19 1936	
SEX		AGE	
MALE		35	
MARRIED		SINGLE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE		INJURY	
POISONING		SUICIDE	
OTHER		OTHER	
PLACE OF DEATH		DATE OF DEATH	
AT HOME		MAY 19 1936	
DECEASED'S NAME		BIRTH OF DECEASED	
JOHN J. BROWN		MAY 19 1936	
SEX		AGE	
MALE		35	
MARRIED		SINGLE	
CAUSE OF DEATH		MANNER OF DEATH	
HEART DISEASE		NATURAL	
DISEASE		INJURY	
POISONING		SUICIDE	
OTHER		OTHER	

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MAR 7 1936  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03042

3088

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <b>District of Columbia</b> COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>49 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>50 The Clinical Center, Bethesda</b>				d. STREET ADDRESS <b>2801 Curtis Drive, S. E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Alan Langtry</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 30, 1954</b>		9. AGE (In years last birthday) yrs. <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James H. Langtry</b>				14. MOTHER'S MAIDEN NAME <b>Shirley Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, bilateral</b> <b>756.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Cystic Fibrosis of the Pancreas</b> DUE TO (c) <b>Congenital</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Feb. 2, 1956</b> , to <b>March 22, 1956</b> , that I last saw the deceased alive on <b>March 22, 1956</b> , and that death occurred at <b>6:35A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lewis E. Gibson</b>				M.D. <b>The Clinical Center, National Institutes of Health</b>			
PHYSICIAN'S NAME (Type) <b>Lewis E. Gibson, M. D.</b>				<b>Bethesda, Maryland</b> <b>3/22/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/26/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. News Co.</b>				ADDRESS <b>2001 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-24-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bruce M. Thompson</b>			

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03043

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">MONTGOMERY</span> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">MARYLAND</span> b. COUNTY <span style="font-size: 1.2em;">MONTGOMERY</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">SILVER SPRING</span>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">SILVER SPRING</span>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">SUNOCO GAS STATION</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">730 SILVER SPRING AVENUE</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">OCTAVIUS</span> Middle <span style="font-size: 1.2em;">U</span> Last <span style="font-size: 1.2em;">LARSEN</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">MARCH</span> Day <span style="font-size: 1.2em;">29</span> Year <span style="font-size: 1.2em;">19 56</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">WHITE</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">5/11/83</span>	
9. AGE (In years last birthday) <span style="font-size: 1.2em;">72</span> yrs.		IF UNDER 1 YEAR Months      Days		IF UNDER 24 HRS. Hours      Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">PLUMBER - Retired</span>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">GEORGIA</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>							
13. FATHER'S NAME <span style="font-size: 1.2em;">UNKNOWN</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">UNKNOWN</span>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-03-8607</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Mrs. Helen Larsen, 730 Silver Spring Ave. Silver Spring, Md.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.5em;">Coronary occlusion</span> DUE TO <span style="font-size: 1.5em;">420.1</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <span style="font-size: 1.2em;">Frank J. Broschart</span> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">FRANK J. BROSCART</span>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <span style="font-size: 1.2em;">3-29-56</span>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		22b. DATE THEREOF <span style="font-size: 1.2em;">3/31/56</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">GEO. WASH. MEM. CEMETERY</span>		22d. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">PRINCE GEO. COUNTY, MD.</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">Warner B. Humphrey</span>				ADDRESS <span style="font-size: 1.2em;">SILVER SPRING, MD.</span>		24a. REC'D BY REGISTRAR <span style="font-size: 1.2em;">4/3/56</span>	
24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em;">Frances C. Cotten</span>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		MILITARY SERVICE		PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CITY		COUNTY		STATE		FEDERAL DISTRICT	

BUREAU V. S.

APR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03044

3090

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wladimir Wassiljevitch Kepeschkin</u>				4. DATE OF DEATH <u>March 22</u> 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 12, 1876</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Scientist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Moscow, Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Wassili Kepeschkin</u>		14. MOTHER'S MAIDEN NAME <u>Alexandra Kotor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertrophied Prostate</u> (c) <u>Hypertrophied Prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 years</u> <u>20 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Advanced General Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>19 March, 1956</u> to <u>22 March, 1956</u> , that I last saw the deceased alive on <u>22 March, 1956</u> , and that death occurred at <u>12:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John G. Ball</u>				M.D. <u>7936 Georgetown Rd. Bethesda Md</u>			
PHYSICIAN'S NAME (Type) <u>John G. Ball- 7936 Georgetown Road, Bethesda, Maryland</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>3-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>8-26-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2998

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03045  
Reg. Dist.

No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Takoma Park</u>		<u>30 yrs</u>		TOWN <u>Takoma Park</u>		<u>17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>512 New York Ave</u>				STREET ADDRESS (If rural, give location) <u>512 New York Ave</u>			
3. NAME OF DECEASED: (First) <u>Ernest Matthew</u>		(Middle) <u>Linthicum</u>		(Last) <u>Linthicum</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX: <u>ma</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>11-25-1886</u>	9. AGE last birthday: <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (work done during most of work life, even if retired): <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Government</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>JOSHUA LINTHICUM</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZA WHITE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>512 NEW YORK AVE, MRS MAY B. LINTHICUM, TAKOMA PARK, MD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						<u>Found dead in basement of this home</u>	
Immediate cause (a) <u>Asphyxia</u>		DUE TO <u>hanging</u>					
Antecedent cause(s) (b) <u>giving rise to the above cause</u>		DUE TO <u>stating underlying cause last</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-22-56 4 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>hanging self by insulated wire</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broshant</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-22-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>MAR 24 1956</u>		NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BYDENSBAKE RD. PR GEO. CO. MD.</u>	
DATE REC'D BY LOCAL REG. <u>3/23/56</u>		REGISTRAR'S SIGNATURE <u>J. William Neale</u>		24. FUNERAL DIRECTOR <u>Richard D. Dally</u>		ADDRESS <u>254 CARRILL ST. N. W. TAKOMA PARK, 12, D.C.</u>	



RECEIVED  
MAR 27 1956  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3020

03046

Reg. Dist. No. 213

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write OR and give nearest town) <u>Rockville</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>323 Lincoln Ave</u>				STREET ADDRESS (If rural, give location) <u>323 Lincoln Ave</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Robert</u>		(Middle) <u>Robert</u>		(Last) <u>Luckett</u>	
4. DATE OF DEATH		(Month) <u>Mar</u>		(Day) <u>8</u>		(Year) <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>col</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH: <u>Jan 27-1956</u>	9. AGE last birthday: <u>1</u> yrs. <u>11</u> Months <u>11</u> Days	IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert N. Luckett</u>				14. MOTHER'S MAIDEN NAME: <u>Clara Jones</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Clara Luckett (mother) Home &amp; Thur 2</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
475X Immediate cause (a) <u>Asphyxia</u> DUE TO Antecedent cause(s) (b) <u>Vomitus</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>upper Respiratory Infection</u>						<u>Found dead in bed</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brosehart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <u>3-8-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/12/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Bayley</u>		24. FUNERAL DIRECTOR <u>Robert L. Sworden</u>		ADDRESS <u>Rockville, Md.</u>	

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MAR 13 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3091

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03047

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>14 Fayette St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Glenn Rice Lysterly</u>				4. DATE OF DEATH Month Day Year <u>March 4 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1922</u>	
9. AGE (In years last birthday) <u>33</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookbinder</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Lee Lysterly</u>				14. MOTHER'S MAIDEN NAME <u>Beulah Correll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Sister Miriam Williams</u>			
17. INFORMANT Address <u>North garden, Va.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, St. Ventricles + Septum</u> DUE TO <u>Acute Ant. Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Route Ant. Coronary Thrombosis</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>3/3/56</u> , 19 <u>56</u> , to <u>3/3/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/3/56</u> , 19 <u>56</u> , and that death occurred at <u>12:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Witowski Jr. M.D.</u>				ADDRESS (Street, city or town, state) <u>8218 Wisconsin Ave. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>EDWARD S. WITOWSKI, JR. M.D.</u>				DATE SIGNED <u>3/5/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial - Transit 3-5-56</u>				22b. DATE THEREOF <u>3-5-56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Unity Presby Ch. Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Salisbury No. Carolina</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>			
24a. REC'D BY REGISTRAR <u>3-6-56</u>				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. SIGNATURE OF PHYSICIAN		10. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		Male		45		1900		Baltimore, Md.		Physician		Heart Disease		Natural		J. H. Harris		J. H. Harris	
11. PLACE OF DEATH		12. DATE OF DEATH		13. TIME OF DEATH		14. SEX OF DECEASED		15. AGE OF DECEASED		16. PLACE OF BIRTH		17. OCCUPATION		18. CAUSE OF DEATH		19. MANNER OF DEATH		20. SIGNATURE OF PHYSICIAN	
Baltimore, Md.		1945		10:00 AM		Male		45		Baltimore, Md.		Physician		Heart Disease		Natural		J. H. Harris	
21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF PHYSICIAN		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS		25. SIGNATURE OF WITNESS		26. SIGNATURE OF WITNESS		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

BUREAU V. S.

MAR 7 1950

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3092

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

03048

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>31 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>3073 S. Woodrow Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mark</b> Middle <b>James</b> Last <b>Marotta</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 14, 1954</b>
9. AGE (In years last birthday) <b>16 mos</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Marotta</b>		14. MOTHER'S MAIDEN NAME <b>June Mortlock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas pneumoniae &amp; septicaemia</b> <b>204.0</b> DUE TO <b>Septic Meningitis &amp; Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Lymphocytic Leukemia</b> (c) <b>Tubercular Hemophili</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 day</b> <b>3 week</b> <b>2 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 17, 1956</b> , to <b>March 19, 1956</b> , that I last saw the deceased alive on <b>March 19, 1956</b> , and that death occurred at <b>9:05 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard D. Fritz</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3 Peaks Hill Rd Bethesda, Md 3-19-56</b>	
PHYSICIAN'S NAME (Type) <b>Richard D. Fritz, M.D.</b>		<b>The Clinical Center, NIH Bethesda, 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Shipment</b>	22b. DATE THEREOF <b>3-20-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>GRACELAND Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Albany, N. Y.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. P. Dineen</b>		ADDRESS <b>Babington 1, K.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	



3093

03049  
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 212

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Montgomery</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Montg</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Dickerson</u>	LENGTH OF STAY (in this place) <u>4 days</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Dickerson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>James</u> (Middle) <u>Franklin</u> (Last) <u>Martin</u>		(Month) <u>Mar</u> (Day) <u>22</u> (Year) <u>1956</u>	
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>6-6-1885</u>
9. AGE last birthday: <u>70</u> yrs.		IF UNDER 1 YEAR: <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>		14. MOTHER'S MAIDEN NAME: <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>223-20-4356</u>	
17. INFORMANT & ADDRESS: <u>Nellie Martin (wife) Same as item 2</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			
Immediate cause (a) <u>Coronary occlusion</u> DUE TO			<u>sudden</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-22-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>	DATE THEREOF: <u>3/24/56</u>	NAME OF CEMETERY OR CREMATORY: <u>Monocoeuy</u>	LOCATION (City, town, or county) (State): <u>Beallsville, Md</u>
DATE REC'D BY LOCAL REG. <u>3/23/56</u>	REGISTRAR'S SIGNATURE: <u>Charles W. Elgin per D.I.E.</u>	24. FUNERAL DIRECTOR: <u>William B. Helton</u> ADDRESS: <u>Beallsville, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 27 1956

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the final copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03050

## 3094 CERTIFICATE OF DEATH

Reg. Dist. No. 215

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Montgomery</u>		STATE <u>Maryland</u> COUNTY <u>Montgomery</u>					
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gaithersburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kensington</u>					
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>The Marylander</u>		STREET ADDRESS (If rural give location) <u>4506 Edgefield Road</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)							
<u>Anna E. May</u>							
<b>4. DATE OF DEATH</b> (Month) (Day) (Year)							
<u>March 7 19 56</u>							
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>				
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>9-2-88</u>				
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)					
<u>67</u> yrs.		<u>IF UNDER 24 HRS.</u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>					
<u>Retired Clerk</u>		<u>U.S. Gov't</u>					
<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>					
<u>Washington, D. C.</u>		<u>USA</u>					
<b>13. FATHER'S NAME</b>		<b>14. MOTHER'S MAIDEN NAME</b>					
<u>William J. McGill</u>		<u>Mary Linskey</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>					
<u>no</u>		<u>578-01-7745</u>					
<b>17. INFORMANT &amp; ADDRESS</b>		<b>18. MEDICAL CERTIFICATION</b>					
<u>Mrs. Emily Sullivan</u>		<u>4506 Edgefield Rd. Kensington, Md.</u>					
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>					
<u>422.1 IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u></u>		<u>6 years</u>					
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>					
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>							
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>					
<b>21f. HOW DID INJURY OCCUR?</b>							
<b>22. I hereby certify that I attended the deceased from <u>March 3, 1955</u>, to <u>March 7, 1956</u>, that I last saw the deceased alive on <u>March 6, 1956</u>, and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>DATE SIGNED</b>					
<u>James P. Kern</u>		<u>3/7/56</u>					
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>24. REC'D BY REGISTRAR</b>					
<u>Burial</u>		<u>3/10/56</u>					
<b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b>					
<u>Mar. 10-56</u>		<u>Alfred L. Cooke</u>					
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>					
<u>Francis J. Collins</u>		<u>Wash. DC</u>					
<u>3821-14th St. N.W.</u>							



# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

Form 10-1-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF NATION

21. SIGNATURE OF WORLD

22. SIGNATURE OF UNIVERSE

23. SIGNATURE OF GOD

24. SIGNATURE OF HEAVEN

25. SIGNATURE OF EARTH

26. SIGNATURE OF FIRE

27. SIGNATURE OF WATER

28. SIGNATURE OF AIR

29. SIGNATURE OF LIGHT

30. SIGNATURE OF DARKNESS

31. SIGNATURE OF LIFE

32. SIGNATURE OF DEATH

33. SIGNATURE OF SLEEP

34. SIGNATURE OF WAKE

35. SIGNATURE OF DREAM

36. SIGNATURE OF REALITY

37. SIGNATURE OF IMAGINATION

38. SIGNATURE OF TRUTH

39. SIGNATURE OF LIE

40. SIGNATURE OF JUSTICE

41. SIGNATURE OF INJUSTICE

42. SIGNATURE OF GOOD

43. SIGNATURE OF EVIL

44. SIGNATURE OF LOVE

45. SIGNATURE OF HATE

46. SIGNATURE OF KINDNESS

47. SIGNATURE OF CRUELTY

48. SIGNATURE OF MERCY

49. SIGNATURE OF PITY

50. SIGNATURE OF GUILT

51. SIGNATURE OF INNOCENCE

52. SIGNATURE OF FAULT

53. SIGNATURE OF VIRTUE

54. SIGNATURE OF VICE

55. SIGNATURE OF HONOR

56. SIGNATURE OF DISHONOR

57. SIGNATURE OF RESPECT

58. SIGNATURE OF DISRESPECT

59. SIGNATURE OF COURAGE

60. SIGNATURE OF COWARDICE

61. SIGNATURE OF BRAVERY

62. SIGNATURE OF TIMIDITY

63. SIGNATURE OF CONFIDENCE

64. SIGNATURE OF DOUBT

65. SIGNATURE OF TRUST

66. SIGNATURE OF SUSPICION

67. SIGNATURE OF FAITH

68. SIGNATURE OF UNFAITH

69. SIGNATURE OF HOPE

70. SIGNATURE OF DESPAIR

71. SIGNATURE OF JOY

72. SIGNATURE OF GRIEF

73. SIGNATURE OF HAPPINESS

74. SIGNATURE OF SADNESS

75. SIGNATURE OF PEACE

76. SIGNATURE OF WAR

77. SIGNATURE OF ORDER

78. SIGNATURE OF CHAOS

79. SIGNATURE OF HARMONY

80. SIGNATURE OF DISHARMONY

81. SIGNATURE OF BEAUTY

82. SIGNATURE OF UGLY

83. SIGNATURE OF CLEAN

84. SIGNATURE OF DIRTY

85. SIGNATURE OF PURE

86. SIGNATURE OF IMPURE

87. SIGNATURE OF SWEET

88. SIGNATURE OF BITTER

89. SIGNATURE OF SOFT

90. SIGNATURE OF HARD

91. SIGNATURE OF GENTLE

92. SIGNATURE OF RUTHLESS

93. SIGNATURE OF COMPASSION

94. SIGNATURE OF MERCY

95. SIGNATURE OF CRUELTY

96. SIGNATURE OF KINDNESS

97. SIGNATURE OF PITY

98. SIGNATURE OF GUILT

99. SIGNATURE OF INNOCENCE

100. SIGNATURE OF FAULT

BUREAU V. S.

MAR 13 1956

RECEIVED

3095

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Blattsburg</u> 69X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>15 Miller St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>S</u> Last <u>McLadden</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 12, 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>New York State</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>B. Hillish</u>		14. MOTHER'S MAIDEN NAME <u>Beaulieu</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Frank R. McLadden</u>		Address <u>15 Miller St. Blattsburg, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arterio Sclerosis</u> DUE TO (c) <u>1 week</u>			INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Nephrosclerosis, Jaundice due to common duct stone</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart Stone</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/24/56</u> to <u>March 3 1956</u> that I last saw the deceased alive on <u>Mar 3</u> 1956, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Curry</u> M.D.		ADDRESS (Street, city or town, state) <u>11301 Georgia Ave Silver Spring, 3/3/56</u>	
PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		DATE SIGNED <u>3/3/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>TRANS. &amp; BURIAL</u>		22b. DATE THEREOF <u>3/3/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETERS CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PLATTSBURG, CLINTON CO., N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u> ADDRESS <u>8434 Georgia Ave Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 8-5-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		M		35		W		10/24/20		MEMPHIS, TENN		4/4/21		MEMPHIS, TENN		HEART DISEASE		NATURAL		JAMES EARL RAY		JAMES EARL RAY	
13. OCCUPATION		14. EDUCATION		15. MARITAL STATUS		16. RELIGION		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
ATTORNEY		HIGH SCHOOL		MARRIED		METHODIST		NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	

RECEIVED  
MAR 7 1956  
BUREAU V. 3

03052

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>1 Mo. 26 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		<b>83x-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NMMC, Bethesda, Md.</b>				d. STREET ADDRESS <b>1983 S. George Mason Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard</b>		First <b>Miles</b>		Middle <b>MC COOL</b>		Last <b>MC COOL</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 July 1885</b>	
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1956</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreign Service Officer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOV'T</b>		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. MC COOL</b>				14. MOTHER'S MAIDEN NAME <b>Georgia A. RAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Richard M. MC COOL Jr.</b> Address <b>1983 Geo. Mason Dr. Arl. Va</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b> <b>162X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Thrombo phlebitis - left leg.</b> DUE TO (c) <b>Bronchogenic Carcinoma - left lung with metastases</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchogenic Carcinoma - left lung with metastases</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>16 Jan.</b> , 19 <b>56</b> , to <b>7 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>7 March</b> , 19 <b>56</b> , and that death occurred at <b>1:04 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda, Maryland</b> DATE SIGNED <b>3-7-56</b> ACTUAL SIGNATURE <b>A. J. Cappelletti</b> M.D. <b>U.S. Naval Hospital, Bethesda, Maryland</b> PHYSICIAN'S NAME (Type) <b>A. J. CAPPELLETTI, LCDR, MC, USN</b> <b>U.S. Naval Hospital, Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Gettysburg, Penna. Private</b>		22d. LOCATION (City, town, or county) (State) <b>Gettysburg, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Wm Lee Sons Co.</b>				ADDRESS <b>Washington, DC</b>		24a. REC'D BY REGISTRAR <b>DATE 7 Mar. 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. E. Russell</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03053

Reg. Dist.

No. 216

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Bethesda</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Bethesda</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8908 Melwood Rd</u>				STREET ADDRESS (If rural, give location) <u>8908 Melwood Rd</u>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last) (Type or Print) <u>Thomas Rutledge McCoy</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>mar 4 19 56</u>			
<b>5. SEX:</b> <u>m</u>	<b>6. COLOR OR RACE:</b> <u>w</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>single</u>	<b>8. DATE OF BIRTH:</b> <u>6-30-47</u>	<b>9. AGE last birthday:</b> yrs. <u>8</u>	<b>IF UNDER 1 YEAR</b> Months <u>8</u> Days <u>4</u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Student</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Student</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Washington, D.C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>Thomas J. McCoy</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Mary A. Rutledge</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY No.:</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Father, Thomas J. McCoy, 8908 Melwood Rd. Beth. Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>Immediate cause</b> (a) <u>Asphyxia</u> <b>Antecedent cause(s)</b> (b) <u>Hanging</u> Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c)						<u>Found dead</u>	
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION:</b>				<b>19b. MAJOR FINDING OF OPERATION:</b>			
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)</b> <u>home</u>		<b>21c. (City or town) (County) (State)</b> <u>Bethesda Montg md</u>			
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b> <u>3-4-56 4:30 P.M.</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>Fell from chain with clothesline about neck</u>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <u>Franz J. Broschiant</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>M. D. ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/> <u>3-4-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-7-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parklawn Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Rockville, Montg. Md</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>3-5-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>		<b>24. FUNERAL DIRECTOR</b> <u>Robert A. Pumphrey</u>		<b>ADDRESS</b> <u>Bethesda, Md.</u>	

BUREAU V. S.

MAR 7 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3098

## CERTIFICATE OF DEATH

03054

Reg. Dist. No. 276

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wood Acres</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6004 Cobalt Rd.</b>		d. STREET ADDRESS <b>6004 Cobalt Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Miles</b> Last <b>Meyer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/6/88</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>St. Paul, Minn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rufus L. Miles</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Sterling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Merle F. Meyer</b>		Address <b>6004 Cobalt Rd. Wood Acres, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> (c) <b>Coronary sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>hours</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-22-52</b> to <b>3-14-56</b> , that I last saw the deceased alive on <b>3-14-1956</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. P. Ryland</b>		ADDRESS (Street, city or town, state) <b>C. P. RYLAND, M.D., 4400 40th St., N. W. Washington 16, D.C.</b>	
DATE SIGNED <b>3-16-56</b>			
PHYSICIAN'S NAME (Type) <b>C. P. Ryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/20/1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. W. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W.</b>	
24a. REC'D BY REGISTRAR <b>DATE 3-19-56</b>		24b. REGISTRAR'S SIGNATURE <b>Beattie M. Thompson</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Room 306, Airport Hotel, Memphis, Tennessee	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. DATE OF BIRTH January 19, 1933		11. PLACE OF BIRTH Jackson, Mississippi		12. OCCUPATION Member of Congress	
13. MARITAL STATUS Single		14. EDUCATION High School Graduate		15. RELIGION Methodist	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF NEXT OF KIN None		18. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
19. SIGNATURE OF CORONER J. Edgar Hoover		20. SIGNATURE OF JURY None		21. SIGNATURE OF WITNESSES None	
22. SIGNATURE OF REGISTRAR J. Edgar Hoover		23. SIGNATURE OF CLERK J. Edgar Hoover		24. SIGNATURE OF CHIEF OF POLICE J. Edgar Hoover	
25. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		26. SIGNATURE OF PROSECUTOR J. Edgar Hoover		27. SIGNATURE OF JUDGE J. Edgar Hoover	
28. SIGNATURE OF CLERK OF COURT J. Edgar Hoover		29. SIGNATURE OF SHERIFF J. Edgar Hoover		30. SIGNATURE OF DEPUTY SHERIFF J. Edgar Hoover	
31. SIGNATURE OF JAILER J. Edgar Hoover		32. SIGNATURE OF CHIEF OF DEPARTMENT J. Edgar Hoover		33. SIGNATURE OF ASSISTANT CHIEF J. Edgar Hoover	
34. SIGNATURE OF SUPERVISOR J. Edgar Hoover		35. SIGNATURE OF INSPECTOR J. Edgar Hoover		36. SIGNATURE OF DETECTIVE J. Edgar Hoover	
37. SIGNATURE OF OFFICER J. Edgar Hoover		38. SIGNATURE OF PATROLMAN J. Edgar Hoover		39. SIGNATURE OF TRAFFIC OFFICER J. Edgar Hoover	
40. SIGNATURE OF RECORDS SECTION J. Edgar Hoover		41. SIGNATURE OF IDENTIFICATION SECTION J. Edgar Hoover		42. SIGNATURE OF LABORATORY J. Edgar Hoover	
43. SIGNATURE OF MEDICAL EXAMINER J. Edgar Hoover		44. SIGNATURE OF PATHOLOGIST J. Edgar Hoover		45. SIGNATURE OF RADIOLOGIST J. Edgar Hoover	
46. SIGNATURE OF CHEMIST J. Edgar Hoover		47. SIGNATURE OF TOXICOLOGIST J. Edgar Hoover		48. SIGNATURE OF ANTHROPOLOGIST J. Edgar Hoover	
49. SIGNATURE OF ENTOMOLOGIST J. Edgar Hoover		50. SIGNATURE OF FORENSIC SCIENTIST J. Edgar Hoover		51. SIGNATURE OF BALLISTICIAN J. Edgar Hoover	
52. SIGNATURE OF FINGERPRINT SECTION J. Edgar Hoover		53. SIGNATURE OF PHOTOGRAPHY SECTION J. Edgar Hoover		54. SIGNATURE OF COMMUNICATIONS SECTION J. Edgar Hoover	
55. SIGNATURE OF TRAINING SECTION J. Edgar Hoover		56. SIGNATURE OF RESEARCH SECTION J. Edgar Hoover		57. SIGNATURE OF PUBLIC AFFAIRS SECTION J. Edgar Hoover	
58. SIGNATURE OF CRIME PREVENTION SECTION J. Edgar Hoover		59. SIGNATURE OF COMMUNITY RELATIONS SECTION J. Edgar Hoover		60. SIGNATURE OF OUTREACH SECTION J. Edgar Hoover	
61. SIGNATURE OF SUPPORT SERVICES SECTION J. Edgar Hoover		62. SIGNATURE OF ADMINISTRATIVE SECTION J. Edgar Hoover		63. SIGNATURE OF FINANCIAL SECTION J. Edgar Hoover	
64. SIGNATURE OF INFORMATION TECHNOLOGY SECTION J. Edgar Hoover		65. SIGNATURE OF LEGAL COUNSEL SECTION J. Edgar Hoover		66. SIGNATURE OF COMPLAINTS SECTION J. Edgar Hoover	
67. SIGNATURE OF INVESTIGATIVE SECTION J. Edgar Hoover		68. SIGNATURE OF ANALYTICAL SECTION J. Edgar Hoover		69. SIGNATURE OF OPERATIONAL SECTION J. Edgar Hoover	
70. SIGNATURE OF SPECIAL INVESTIGATIVE SECTION J. Edgar Hoover		71. SIGNATURE OF RESEARCH AND ANALYSIS SECTION J. Edgar Hoover		72. SIGNATURE OF TRAINING AND DEVELOPMENT SECTION J. Edgar Hoover	
73. SIGNATURE OF PROFESSIONAL DEVELOPMENT SECTION J. Edgar Hoover		74. SIGNATURE OF QUALITY ASSURANCE SECTION J. Edgar Hoover		75. SIGNATURE OF COMPLIANCE SECTION J. Edgar Hoover	
76. SIGNATURE OF RISK MANAGEMENT SECTION J. Edgar Hoover		77. SIGNATURE OF SAFETY SECTION J. Edgar Hoover		78. SIGNATURE OF SECURITY SECTION J. Edgar Hoover	
79. SIGNATURE OF BUSINESS AFFAIRS SECTION J. Edgar Hoover		80. SIGNATURE OF GENERAL INVESTIGATIVE SECTION J. Edgar Hoover		81. SIGNATURE OF IDENTIFICATION SECTION J. Edgar Hoover	
82. SIGNATURE OF LABORATORY SECTION J. Edgar Hoover		83. SIGNATURE OF MEDICAL EXAMINER SECTION J. Edgar Hoover		84. SIGNATURE OF PATHOLOGIST SECTION J. Edgar Hoover	
85. SIGNATURE OF RADIOLOGIST SECTION J. Edgar Hoover		86. SIGNATURE OF CHEMIST SECTION J. Edgar Hoover		87. SIGNATURE OF TOXICOLOGIST SECTION J. Edgar Hoover	
88. SIGNATURE OF ANTHROPOLOGIST SECTION J. Edgar Hoover		89. SIGNATURE OF ENTOMOLOGIST SECTION J. Edgar Hoover		90. SIGNATURE OF FORENSIC SCIENTIST SECTION J. Edgar Hoover	
91. SIGNATURE OF BALLISTICIAN SECTION J. Edgar Hoover		92. SIGNATURE OF FINGERPRINT SECTION J. Edgar Hoover		93. SIGNATURE OF PHOTOGRAPHY SECTION J. Edgar Hoover	
94. SIGNATURE OF COMMUNICATIONS SECTION J. Edgar Hoover		95. SIGNATURE OF TRAINING SECTION J. Edgar Hoover		96. SIGNATURE OF RESEARCH SECTION J. Edgar Hoover	
97. SIGNATURE OF PROFESSIONAL DEVELOPMENT SECTION J. Edgar Hoover		98. SIGNATURE OF QUALITY ASSURANCE SECTION J. Edgar Hoover		99. SIGNATURE OF COMPLIANCE SECTION J. Edgar Hoover	
100. SIGNATURE OF RISK MANAGEMENT SECTION J. Edgar Hoover		101. SIGNATURE OF SAFETY SECTION J. Edgar Hoover		102. SIGNATURE OF SECURITY SECTION J. Edgar Hoover	

BUREAU V. S.

MAR 22 1968

RECEIVED

3099

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sharon Chronic Hospital</b>		d. STREET ADDRESS <b>4504 Burlington Rd</b>	
3. NAME OF DECEASED (Type or print) First <b>Nannie E</b> Middle <b>Michael</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>20</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1863</b>
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Frederick Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Charles Flamming</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Myron M Michael</b>		Address <b>Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Emaciation + Cachexia</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uterine ca - Metastases -</b> (c) <b>Generalized</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>3 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-18</b> , 19 <b>55</b> , to <b>3-20</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3-20-56</b> , 19 <b>56</b> , and that death occurred at <b>7:39 P. M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John Boskey Ziegler</b> M.D. <b>Olney, Md</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>3-20-56</b>	
PHYSICIAN'S NAME (Type) <b>JOHN BOSKEY ZIEGLER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/23/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Busch's sons</b>		ADDRESS <b>Hyattsville Md</b>	
24a. REC'D BY REGISTRAR DATE <b>3-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Estimude B Lawler</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

3 3 03

11-11

<p>1. NAME OF DECEASED                  [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX                  [Handwritten: <i>Male</i>]</p>	
<p>3. AGE                  [Handwritten: <i>45</i>]</p>		<p>4. DATE OF BIRTH                  [Handwritten: <i>1910</i>]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: <i>Baltimore, Md.</i>]</p>		<p>6. OCCUPATION                  [Handwritten: <i>Teacher</i>]</p>	
<p>7. CAUSE OF DEATH                  [Handwritten: <i>Heart Disease</i>]</p>		<p>8. MANNER OF DEATH                  [Handwritten: <i>Natural</i>]</p>	
<p>9. DATE OF DEATH                  [Handwritten: <i>March 28, 1956</i>]</p>		<p>10. TIME OF DEATH                  [Handwritten: <i>10:00 AM</i>]</p>	
<p>11. PLACE OF DEATH                  [Handwritten: <i>Home</i>]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Handwritten: <i>John Doe</i>]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [Handwritten: <i>John Doe</i>]</p>		<p>14. SIGNATURE OF WITNESS                  [Handwritten: <i>John Doe</i>]</p>	

BUREAU V. S.

MAR 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03056

3100

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>Bethesda,</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>Approx 7 mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u> <u>56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>National Institutes of Health</u>				d. STREET ADDRESS <u>9618 Cottrell Terrace</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Linda</u> <u>A</u> <u>MOKREN</u> <u>Mokren</u>				4. DATE OF DEATH Month Day Year <u>March</u> <u>24</u> <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1948</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>(child)</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>Morris Mokren</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Shirley Mokren (Same as deceased)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomembranous enterocolitis</u> <u>2043</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute leukemia</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>18 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hemorrhagic ascites</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> to <u>March 24, 1956</u> , that I last saw the deceased alive on <u>March 24, 1956</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Horace Wright Bernton</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Clinical Center</u> <u>3/24/56</u>			
PHYSICIAN'S NAME (Type) <u>Horace Wright Bernton, M.D.</u>				<u>Bethesda, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Hyattsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Goldberg Funeral Home</u>				ADDRESS <u>4217 - 9145th. nw</u>		24a. REC'D BY REGISTRAR <u>DATE 3-27-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			

**BUREAU V. S.**

MAR 29 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2999

## CERTIFICATE OF DEATH

Reg. Dist. No.

030573

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>15 Washington Sanitarium &amp; Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park 17</u>			
f. STREET ADDRESS <u>7302 16th Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Irene</u>		First <u>Maudie</u>		Middle <u>Muller</u>		Last	
4. DATE OF DEATH <u>3 - 14 - 1956</u>		Month		Day		Year	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-1886</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Clerk Typist - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Wingrove</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Coudy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>577-20-5725A</u>		17. INFORMANT <u>Washington Sanitarium &amp; Hospital Records, TX, PK 10</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL VASCULAR ACCIDENT</u> DUE TO (c) <u>ARTERIOSCLEROTIC HT DISEASE</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 HRS.</u> <u>2 1/4 MOS.</u> <u>3-4 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 20</u> , 19 <u>56</u> , to <u>MARCH 14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MARCH 13</u> , 19 <u>56</u> , and that death occurred at <u>2:05 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harold Sterling</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>3/14/56</u>			
PHYSICIAN'S NAME (Type) <u>HAROLD STERLING</u>				<u>1352 UNIVERSITY LANE, HYATTSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey S.S., MD.</u>				ADDRESS <u>8434 44th Ave</u>		24a. REC'D BY REGISTRAR DATE <u>3/16/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wilson Dodd</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## CERTIFICATE OF DEATH

Reg. Dist. No. 223

3700

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-15-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary Ellen Mullery</u>				4. DATE OF DEATH <u>3 18 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-11-74</u> yrs.	
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>Ireland</u>				12. CITIZEN OF WHAT COUNTRY? <u>America</u>			
13. FATHER'S NAME <u>John Murphy</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>Washington Sanitarium Hospital Record</u>				Address <u>Takoma Park Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure due to diabetes</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho pneumonia</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>March 1, 1956</u> , to <u>March 18, 1956</u> , that I last saw the deceased alive on <u>March 17, 1956</u> , and that death occurred at <u>12:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Eino Magi</u>				ADDRESS (Street, city or town, state) <u>8401 University Lane S.E., Ind.</u>			
PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>				DATE SIGNED <u>3/18/56</u>			
22a. DATE OF CREMATION, BURIAL, OR OTHER REMOVAL (Specify) <u>3/18/1956</u>				22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Queens County, New York</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.W. Chambers</u>				ADDRESS <u>1400 Chapin St N.W. Wash, D.C.</u>			
24a. REC'D BY REGISTRAR <u>3/20/56</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilson</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. PLACE OF BIRTH		14. DATE OF BIRTH	
15. NAME OF FATHER		16. NAME OF MOTHER	
17. NAME OF SPOUSE		18. NAME OF CHILD	
19. NAME OF GRANDCHILD		20. NAME OF GREAT-GRANDCHILD	
21. NAME OF GREAT-GRANDCHILD		22. NAME OF GREAT-GRANDCHILD	
23. NAME OF GREAT-GRANDCHILD		24. NAME OF GREAT-GRANDCHILD	
25. NAME OF GREAT-GRANDCHILD		26. NAME OF GREAT-GRANDCHILD	
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51. NAME OF GREAT-GRANDCHILD		52. NAME OF GREAT-GRANDCHILD	
53. NAME OF GREAT-GRANDCHILD		54. NAME OF GREAT-GRANDCHILD	
55. NAME OF GREAT-GRANDCHILD		56. NAME OF GREAT-GRANDCHILD	
57. NAME OF GREAT-GRANDCHILD		58. NAME OF GREAT-GRANDCHILD	
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65. NAME OF GREAT-GRANDCHILD		66. NAME OF GREAT-GRANDCHILD	
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79. NAME OF GREAT-GRANDCHILD		80. NAME OF GREAT-GRANDCHILD	
81. NAME OF GREAT-GRANDCHILD		82. NAME OF GREAT-GRANDCHILD	
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89. NAME OF GREAT-GRANDCHILD		90. NAME OF GREAT-GRANDCHILD	
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93. NAME OF GREAT-GRANDCHILD		94. NAME OF GREAT-GRANDCHILD	
95. NAME OF GREAT-GRANDCHILD		96. NAME OF GREAT-GRANDCHILD	
97. NAME OF GREAT-GRANDCHILD		98. NAME OF GREAT-GRANDCHILD	
99. NAME OF GREAT-GRANDCHILD		100. NAME OF GREAT-GRANDCHILD	

RECEIVED  
MAR 21 1956  
BUREAU V. 8

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3101

CERTIFICATE OF DEATH

03059

Reg. Dist. No. 246

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>17 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lewistown</b>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>Glenn</b> Last <b>Murphy</b>		4. DATE OF DEATH Month <b>March</b> Day <b>22</b> , Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 26, 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Industry</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Elmer Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Bordner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>332-10-5866</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SHOCK</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>POST-OPERATIVE</b> <b>AORTIC INSUFFICIENCY, RHEUMATIC</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 19 56</b> , to <b>March 22, 19 56</b> , that I last saw the deceased alive on <b>March 22, 1956</b> , and that death occurred at <b>2:02 p.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Salerno</b>		M.D. <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Salerno, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda, Maryland</b>	
22a. DATE OF BURIAL, CREMATION, OR REMOVAL (Specify) <b>3/24/56</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Lewistown, Illinois</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Dines Co.</b>		ADDRESS <b>Wash, D.C.</b> <b>2901 14th St. N.W.</b>	
24a. REC'D BY REGISTRAR <b>Bessie M. Thompson</b>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

Name of Deceased Robert A. Johnson		Sex Male		Age 35		Date of Birth March 12, 1925	
Place of Birth Chicago, Ill.		Usual Residence Chicago, Ill.		Cause of Death Heart Disease		Manner of Death Natural	
Occupation Salesman		Education High School		Marital Status Married		Date of Marriage June 15, 1948	
Name of Physician Dr. J. H. Smith		Name of Hospital St. Mary's Hospital		Date of Death March 15, 1956		Place of Death Chicago, Ill.	
Name of Informant Mrs. Robert A. Johnson		Relationship to Deceased Wife		Signature of Informant (Signature)		Signature of Physician (Signature)	
City Chicago		County Cook		State Illinois		Year 1956	

BUREAU V. S.

MAR 23 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3001

## CERTIFICATE OF DEATH

03060

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>634 Sligo Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Agnes</u> Last <u>Murphy</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4 1883</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>72</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>72</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Suhre</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Medical Records Washington San. and Hosp.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X</u> <u>Advanced Carcinomatous Metastases</u> DUE TO <u>Advanced Carcinoma of Liver 2 Ascites</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>(b) Esophagus Metastases (severe)</u> DUE TO <u>Chronic Interstitial Nephritis</u> <u>(c) Advanced Arteriosclerotic heart + kidneys</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Left Hemiplegia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1938</u> , 19 <u>56</u> , to <u>3-27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 27</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kenneth F. Laughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>934 Ellsworth Dr. Silver Spring, Md.</u> DATE SIGNED <u>3-27-56</u>			
PHYSICIAN'S NAME (Type) <u>KENNETH F. LAUGHLIN</u>				934 ELLSWORTH DRIVE, SILVER SPRING, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Humphrey</u> ADDRESS <u>SILVER SPRING, MD.</u>				24a. REC'D BY REGISTRAR <u>3/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nelson Pratt</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 4, Film G196 4-23-56 et  
3102  
CERTIFICATE OF DEATH

03061

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>30 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hospital, Inc.</u>				d. STREET ADDRESS <u>Rt 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Dorsey</u> Middle <u>Bussard</u> Last <u>Myers</u>				4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>56</u> (Correct) 19 <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/??/66</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Phillip Myers</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Corn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Right Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>32 days</u> <u>32 days</u> <u>Don't know</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/2</u> , 19 <u>56</u> , to <u>3/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/4</u> , 19 <u>55</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M.D.</u>				<u>Sandy Spring, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-7-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Airy Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-7-56</u>	
						24b. REGISTRAR'S SIGNATURE <u>Gertrude B. Fowler</u>	

112

BUREAU V. S.

MAR 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3103

## CERTIFICATE OF DEATH

03062

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
f. STREET ADDRESS <b>2940 Chain Bridge Road, N.W.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>Barton</b> Last <b>Myers</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 13, 1901</b>
9. AGE (In years for birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Economist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Economic Development Iowa</b>	
11. BIRTHPLACE (State or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leonard Barton</b>		14. MOTHER'S MAIDEN NAME <b>Della Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, lung, metastatic</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 20, 1956</b> , to <b>March 9, 1956</b> , that I last saw the deceased alive on <b>March 9, 1956</b> , and that death occurred at <b>6:18 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bernard Robert Landau</b> M.D.		ADDRESS (Street, city or town, state) <b>The Clinical Center, NIH, Bethesda, Md.</b> DATE SIGNED <b>3/9/56</b>	
PHYSICIAN'S NAME (Type) <b>Bernard Robert Landau, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>3-12-56 Nat-mem. Park</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <b>Falls Ch. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jos. Gawlus Sons</b> ADDRESS <b>1756 P Ave N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>3-13-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	

RECEIVED

BUREAU V. S.

1956 5 24



3104

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>5825 Osceola Road</b>				d. STREET ADDRESS <b>5825 Osceola Road</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charlotte Ruth Nave</b>				4. DATE OF DEATH Month Day Year <b>March 24 19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/28/1905</b>	9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bookkeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nave Typograph-ical Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Ruth, Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Augustus Seltz</b>				14. MOTHER'S MAIDEN NAME <b>Rosa Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Ruth A. Simpson - 5108 Baltimore Ave., Washington 16, D.C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162X Branchogenic carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 19 55</b> to <b>Mar. 24 56</b> , that I last saw the deceased alive on <b>Mar 24 56</b> , and that death occurred at <b>10:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C P Ryland</b>				M.D. <b>4402 - 49th St NW</b>		DATE SIGNED <b>3-24-56</b>	
PHYSICIAN'S NAME (Type) <b>Washington DC</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>3/27/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Davis Co.</b>				ADDRESS <b>2901 14th St. N.W.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

*Phomopsis canescens*

22 Nov-34 26 BUREAU V. S.

*(Handwritten signature)*

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9561



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 3702

## CERTIFICATE OF DEATH

## 03064

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>2 hrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. &amp; Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Montgomery</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> d. STREET ADDRESS <u>16 Belmont Court</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Jesse</u> Middle <u>(none)</u> Last <u>Newton</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>16</u> Year <u>1956</u>							
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>10-14-90</u>		<b>9. AGE</b> (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Naval gun factory</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>D.C.</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>U. S. A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>America</u>	
<b>13. FATHER'S NAME</b> <u>Jesse Newton</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Katie Cox</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> Address <u>Mrs. Selma R. Newton (same)</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>one hour</u> <u>unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes Mellitus</u>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I attended the deceased from</b> <u>3-16</u> , 19 <u>56</u> , to <u>3-16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-16</u> , 19 <u>56</u> , and that death occurred at <u>9:50</u> M, from the causes and on the date stated above.											
<b>ACTUAL SIGNATURE</b> <u>Robert A Hare, M.D.</u>						<b>ADDRESS</b> (Street, city or town, state) <u>7600 Carroll Ave. (cleared by Coroner)</u>				<b>DATE SIGNED</b>	
<b>PHYSICIAN'S NAME</b> (Type) <u>Robert A Hare, M.D.</u>						<u>Takoma Park Md.</u>					
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>3-19-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Cem.</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>Prince Georges Co Md.</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Thos. A. Hines</u>						<b>ADDRESS</b> <u>2901-14th St. N.W. Wash. D.C.</u>		<b>24a. REC'D BY REGISTRAR</b> DATE <u>3/19/56</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. Alton Dodd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MR 21 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03065

3105

## CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7002 Conn. Ave</b>				d. STREET ADDRESS <b>7002 Conn. Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILL</b>		First <b>D</b> Middle <b>NICHOLS</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-22-1870</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>9</b> Days <b>7</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Draftsman Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>David Nichols</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dorothy Nichols, 7002 Conn. Ave. Ch. Ch. Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>42a1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>900.0</b> (b) <b>Arteriosclerosis, generalized &amp;</b> DUE TO (c) <b>Hypertension</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>20 yrs.</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, rib femoral neck (12/55). Ulcer duodenum</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell on back step of home</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Chevy Chase, Md.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>Nov. 12, 1955</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					
21. I certify that I attended the deceased from <b>Nov. 12, 1955</b> , to <b>March 23, 1956</b> , that I last saw the deceased alive on <b>Mar. 22, 1956</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip H. Varner, M.D.</b>				ADDRESS (Street, city or town, state) <b>7702 Conn. Ave.</b>		DATE SIGNED <b>Mar. 23, 1956</b>	
PHYSICIAN'S NAME (Type) <b>Philip H. Varner</b>				<b>Chevy Chase, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-26-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-26-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>			



Montgomery Co. Medical Examiner  
notified & will approve.

O. A. Warner, M.D.

3/23/50

BUREAU V. S.

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>273 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center</b> <b>National Institutes of Health</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b> <b>16-15-2</b>			
d. STREET ADDRESS <b>7739 Frederic Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>Philip</b> Last <b>Nimro Jr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1900</b>		9. AGE (In years last birthday) <b>55</b> yrs.	10. IF UNDER 1 YEAR Months <b>11</b> Days <b>14</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>		11. BIRTHPLACE (State or foreign country) <b>Conn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Bernard Nimro</b>				14. MOTHER'S MAIDEN NAME <b>Letitia Witt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		(If yes, give year or dates of service) <b>WW # 1</b>		16. SOCIAL SECURITY NO. <b>577-44-0974</b>		17. INFORMANT <b>The Medical Record, The Clinical Center</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic Mitral Insufficiency</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1955</b> to <b>March 14, 1956</b> , that I last saw the deceased alive on <b>March 14, 1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John Davidson</b>				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>John Davidson, M. D.</b>				DATE SIGNED <b>3/15/56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Mar 19, 1956</b>		<b>Arlington National</b>		<b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Co. Washington, D.C.</b>				24a. REC'D BY REGISTRAR <b>1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Donnelly</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

See the back

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		5-3-28		MOBILE, ALABAMA	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE	
MARRIED		1-1-55		MEMPHIS, TENNESSEE	
OCCUPATION		DATE OF DEATH		PLACE OF DEATH	
CONTRACTOR		4-4-68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		DATE OF AUTOPSY		PLACE OF AUTOPSY	
HEART DISEASE		4-4-68		MEMPHIS, TENNESSEE	
MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
NATURAL		4-4-68		MEMPHIS, TENNESSEE	
EDUCATION		DATE OF INTERMENT		PLACE OF INTERMENT	
HIGH SCHOOL		4-4-68		MEMPHIS, TENNESSEE	
RELIGION		DATE OF CREMATION		PLACE OF CREMATION	
METHODIST		4-4-68		MEMPHIS, TENNESSEE	
SPECIAL INSTRUCTIONS		DATE OF EXHUMATION		PLACE OF EXHUMATION	
		4-4-68		MEMPHIS, TENNESSEE	

BUREAU V. 51

MAR 20 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3107  
CERTIFICATE OF DEATH03067  
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>VIRGINIA</b> b. COUNTY <b>Arlington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Rural</b>		c. LENGTH OF STAY IN 1b <b>23 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00</b>		d. STREET ADDRESS <b>3108 N. Pershing Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Warren</b> Last <b>NORRIS</b>		4. DATE OF DEATH Month <b>march</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>22 march 1889</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Marine Corps (Ret.)</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>warren NORRIS</b>		14. MOTHER'S MAIDEN NAME <b>Olivia DNUCE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> WW I & II		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Wife) Mrs. Mary M. NORRIS</b>		Address: <b>3108 N. Pershing Dr Arlington, Va.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0 ARTERIO-SCLEROTIC HEART DISEASE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 Feb.</b> , 19 <b>56</b> , to <b>5 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5 March</b> , 19 <b>56</b> , and that death occurred at <b>12:07 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. R. Davis</b>		DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 3-5-56</b>	
PHYSICIAN'S NAME (Type) <b>J. R. DAVIS, CDR, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7 March 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. E. Fulphin</b>		24a. REC'D BY REGISTRAR <b>Mar. 5 Mar 56</b>	
24b. REGISTRAR'S SIGNATURE <b>Mary E. Parselley</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03068

3108

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10701 Rockville Pike</b>				d. STREET ADDRESS <b>10701 Rockville Pike</b>			
3. NAME OF DECEASED (Type or print) <b>Sister M. Clemenza-Margaret Nugent</b>				4. DATE OF DEATH Month <b>March</b> Day <b>16</b> Year <b>1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 22, 1889</b>	
9. AGE (In years last birthday) yrs. <b>66</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b> Hours <b></b> Min. <b></b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		11. BIRTHPLACE (State or foreign country) <b>Alexandria, Va.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nun</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nun</b>		11. BIRTHPLACE (State or foreign country) <b>Alexandria, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Nugent</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Burns</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Sisters at St. Angela Hall-Pike, Rockville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 myocardial failure</b> DUE TO <b>myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b> DUE TO <b>Coronary arteriosclerosis</b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b> <b>3 hrs.</b> <b>Indef.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>2/1/56</b> , to <b>3/16/56</b> , that I last saw the deceased alive on <b>3/16/56</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen M. Jones</b> M.D.				ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>			
DATE SIGNED <b>3/17/56</b>							
PHYSICIAN'S NAME (Type) <b>Stephen M. Jones</b>				Rockville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda Md</b>		24a. REC'D BY REGISTRAR <b>DATE 3-19-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Bennie M. Thompson</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESS	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERK		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF SHERIFF		18. SIGNATURE OF CORONER	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF COUNTY CLERK		21. SIGNATURE OF TOWNSHIP CLERK	
22. SIGNATURE OF VILLAGE CLERK		23. SIGNATURE OF POST OFFICE CLERK		24. SIGNATURE OF SCHOOL CLERK	
25. SIGNATURE OF CHURCH CLERK		26. SIGNATURE OF CEMETERY CLERK		27. SIGNATURE OF FUNERAL HOME	
28. SIGNATURE OF BURIAL SOCIETY		29. SIGNATURE OF INTERMENT SOCIETY		30. SIGNATURE OF OTHER SOCIETY	
31. SIGNATURE OF OTHER SOCIETY		32. SIGNATURE OF OTHER SOCIETY		33. SIGNATURE OF OTHER SOCIETY	
34. SIGNATURE OF OTHER SOCIETY		35. SIGNATURE OF OTHER SOCIETY		36. SIGNATURE OF OTHER SOCIETY	
37. SIGNATURE OF OTHER SOCIETY		38. SIGNATURE OF OTHER SOCIETY		39. SIGNATURE OF OTHER SOCIETY	
40. SIGNATURE OF OTHER SOCIETY		41. SIGNATURE OF OTHER SOCIETY		42. SIGNATURE OF OTHER SOCIETY	
43. SIGNATURE OF OTHER SOCIETY		44. SIGNATURE OF OTHER SOCIETY		45. SIGNATURE OF OTHER SOCIETY	
46. SIGNATURE OF OTHER SOCIETY		47. SIGNATURE OF OTHER SOCIETY		48. SIGNATURE OF OTHER SOCIETY	
49. SIGNATURE OF OTHER SOCIETY		50. SIGNATURE OF OTHER SOCIETY		51. SIGNATURE OF OTHER SOCIETY	
52. SIGNATURE OF OTHER SOCIETY		53. SIGNATURE OF OTHER SOCIETY		54. SIGNATURE OF OTHER SOCIETY	
55. SIGNATURE OF OTHER SOCIETY		56. SIGNATURE OF OTHER SOCIETY		57. SIGNATURE OF OTHER SOCIETY	
58. SIGNATURE OF OTHER SOCIETY		59. SIGNATURE OF OTHER SOCIETY		60. SIGNATURE OF OTHER SOCIETY	
61. SIGNATURE OF OTHER SOCIETY		62. SIGNATURE OF OTHER SOCIETY		63. SIGNATURE OF OTHER SOCIETY	
64. SIGNATURE OF OTHER SOCIETY		65. SIGNATURE OF OTHER SOCIETY		66. SIGNATURE OF OTHER SOCIETY	
67. SIGNATURE OF OTHER SOCIETY		68. SIGNATURE OF OTHER SOCIETY		69. SIGNATURE OF OTHER SOCIETY	
70. SIGNATURE OF OTHER SOCIETY		71. SIGNATURE OF OTHER SOCIETY		72. SIGNATURE OF OTHER SOCIETY	
73. SIGNATURE OF OTHER SOCIETY		74. SIGNATURE OF OTHER SOCIETY		75. SIGNATURE OF OTHER SOCIETY	
76. SIGNATURE OF OTHER SOCIETY		77. SIGNATURE OF OTHER SOCIETY		78. SIGNATURE OF OTHER SOCIETY	
79. SIGNATURE OF OTHER SOCIETY		80. SIGNATURE OF OTHER SOCIETY		81. SIGNATURE OF OTHER SOCIETY	
82. SIGNATURE OF OTHER SOCIETY		83. SIGNATURE OF OTHER SOCIETY		84. SIGNATURE OF OTHER SOCIETY	
85. SIGNATURE OF OTHER SOCIETY		86. SIGNATURE OF OTHER SOCIETY		87. SIGNATURE OF OTHER SOCIETY	
88. SIGNATURE OF OTHER SOCIETY		89. SIGNATURE OF OTHER SOCIETY		90. SIGNATURE OF OTHER SOCIETY	
91. SIGNATURE OF OTHER SOCIETY		92. SIGNATURE OF OTHER SOCIETY		93. SIGNATURE OF OTHER SOCIETY	
94. SIGNATURE OF OTHER SOCIETY		95. SIGNATURE OF OTHER SOCIETY		96. SIGNATURE OF OTHER SOCIETY	
97. SIGNATURE OF OTHER SOCIETY		98. SIGNATURE OF OTHER SOCIETY		99. SIGNATURE OF OTHER SOCIETY	
100. SIGNATURE OF OTHER SOCIETY		101. SIGNATURE OF OTHER SOCIETY		102. SIGNATURE OF OTHER SOCIETY	

BUREAU V. S.

MAR 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completed. It should be filed in the funeral director's file. After this certificate is filed, the funeral director should file it in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

03069

Reg. Dist. No. 216

3109

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>4914 Sedgwick St. N.W.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thomas Loehl O'Brien</u>		4. DATE OF DEATH Month Day Year <u>March 20 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1912</u>
9. AGE (In years last birthday) <u>43</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>47x-3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pension Consultant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Life Ins. Executive</u>	
11. BIRTHPLACE (State or foreign country) <u>Wash., D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Mary Loehl</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Anne C. O'Brien, (as Above)</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>155x Cholangitis</u> DUE TO <u>Adenocarcinoma bile duct</u> (b) <u>intra-hepatic</u> DUE TO <u>Bronchopneumonia</u> (c) <u>Bronchopneumonia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>Feb. 1, 1956</u> , to <u>3-20</u> , 1956, that I last saw the deceased alive on <u>3-20</u> , 1956, and that death occurred at <u>5:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Morton C. Creditor</u>		ADDRESS (Street, city or town, state) <u>Washington Clinic, Wash., D.C.</u>	
PHYSICIAN'S NAME (Type) <u>Morton C. Creditor</u>		DATE SIGNED <u>3/20/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/21/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawley Sons</u>		ADDRESS <u>1756 Pa. Ave. N.W., Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>3-21-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bernard Thompson</u>	

MAR 22 1956

RECEIVED

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> <b>47X-3</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 7300 BALTIMORE AVE. Cedar Haven Rest Home</b>		d. STREET ADDRESS <b>3615 ORDWAY ST N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>ODDENINO</b> Last <b>ODDENINO</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-61</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>Joseph Cadenino</b>		14. MOTHER'S MAIDEN NAME <b>CELINA PARACEA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Cedar Haven Rest Home Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 weeks</b> <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition and Acidosis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1953</b> , to <b>March 10, 1956</b> , that I last saw the deceased alive on <b>March 9, 1956</b> , and that death occurred at <b>12 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wallace N. Meek</b> M.D. <b>7701 Carroll Avenue</b>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Wallace N. Meek M.D. Takoma Park 12 Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-12-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>3821-14TH. N.W. Wash. D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>3-12-56</b> 24b. REGISTRAR'S SIGNATURE <b>J. Allen Holt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>NAME (Last, first, middle)                  JOSEPH CATHERINE</p>		<p>DATE OF BIRTH                  10-1-1894</p>		<p>PLACE OF BIRTH                  BALTIMORE, MARYLAND</p>	
<p>DATE OF DEATH                  10-1-1956</p>		<p>PLACE OF DEATH                  BALTIMORE, MARYLAND</p>		<p>CAUSE OF DEATH                  (To be filled by physician)</p>	
<p>SEX                  FEMALE</p>		<p>RACE                  WHITE</p>		<p>EDUCATION                  (To be filled by physician)</p>	
<p>RELIGION                  (To be filled by physician)</p>		<p>OCCUPATION                  (To be filled by physician)</p>		<p>PREVIOUS ILLNESS                  (To be filled by physician)</p>	
<p>DIAGNOSIS                  (To be filled by physician)</p>		<p>TESTS                  (To be filled by physician)</p>		<p>TREATMENT                  (To be filled by physician)</p>	
<p>DATE OF EXAMINATION                  10-1-1956</p>		<p>PLACE OF EXAMINATION                  BALTIMORE, MARYLAND</p>		<p>EXAMINER                  (To be filled by physician)</p>	
<p>SIGNATURE OF DECEASED                  (To be filled by physician)</p>		<p>SIGNATURE OF WITNESS                  (To be filled by physician)</p>		<p>SIGNATURE OF PHYSICIAN                  (To be filled by physician)</p>	

BUREAU V. 1

MAR 13 1956

RECEIVED

3704

## CERTIFICATE OF DEATH

Reg. Dist. No.

0307123

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San. Hosp.</u>				d. STREET ADDRESS <u>301 Hamilton St. N.W. Apt. 2</u>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Anna</u> First <u>(none)</u> Middle <u>Estrich</u> Last				4. DATE OF DEATH <u>March</u> Month <u>30</u> Day <u>1956</u> Year			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>unknown</u> about <u>64</u> yrs.	
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Taylor, Ralph</u>				14. MOTHER'S MAIDEN NAME <u>Gurvitz, Bessie Rose</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>patient's chart-</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis acute</u> 260X DUE TO <u>Diabetes MELLITUS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>Arteriosclerosis, generalized</u>							INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug</u> , 19 <u>54</u> , to <u>March 30</u> 19 <u>56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>8:00 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. A. Hillman</u>				ADDRESS (Street, city or town, state) <u>249 Missouri AVE N.W</u>			
DATE SIGNED <u>3-30-56</u>							
PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 1/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Talmud Torah Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Congress Heights D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargansky &amp; Son</u>				ADDRESS <u>3501-14th St. N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>4/3/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Patricia Dodd</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3110

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH _____	
NAME OF DECEASED _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
AGE _____		RACE _____	
PLACE OF BIRTH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
TIME OF DEATH _____		SIGNATURE OF PHYSICIAN _____	
SIGNATURE OF REGISTRAR _____		SIGNATURE OF WITNESS _____	
DATE OF REGISTRATION _____		TIME OF REGISTRATION _____	
PLACE OF REGISTRATION _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF SURVIVOR _____	
SIGNATURE OF BURIAL SOCIETY _____		SIGNATURE OF FUNERAL HOME _____	
SIGNATURE OF CHURCH _____		SIGNATURE OF CEMETERY _____	
SIGNATURE OF MINISTRY _____		SIGNATURE OF CLERGY _____	
SIGNATURE OF MINISTER _____		SIGNATURE OF DEACON _____	
SIGNATURE OF ELDER _____		SIGNATURE OF RULING ELDER _____	
SIGNATURE OF MODERATOR _____		SIGNATURE OF CLERK _____	
SIGNATURE OF TREASURER _____		SIGNATURE OF SECRETARY _____	
SIGNATURE OF CHURCH _____		SIGNATURE OF CEMETERY _____	
SIGNATURE OF MINISTRY _____		SIGNATURE OF CLERGY _____	
SIGNATURE OF MINISTER _____		SIGNATURE OF DEACON _____	
SIGNATURE OF ELDER _____		SIGNATURE OF RULING ELDER _____	
SIGNATURE OF MODERATOR _____		SIGNATURE OF CLERK _____	
SIGNATURE OF TREASURER _____		SIGNATURE OF SECRETARY _____	

BUREAU V. 2

APR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3705

## CERTIFICATE OF DEATH

03072

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Maryland</u>		c. LENGTH OF STAY IN 1b <u>26 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mr. Madeline Cochran Partello</u>		4. DATE OF DEATH Month Day Year <u>March 13 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1893</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy</u>	
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Joseph Partello</u>		14. MOTHER'S MAIDEN NAME <u>Anna Virginia Noonan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Oct 6, 1918 - 1946</u>		16. SOCIAL SECURITY NO. <u>YES</u>	
17. INFORMANT <u>MRS. SABINA C. PARTELLO, 2109 HILDAROSE DRIVE</u>		Address <u>SILVER SPRING, MARYLAND</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, rt. coronary artery</u> <u>150x and</u> DUE TO <u>Aspiration pneumonia, left lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of esophagus</u> (c) <u>Thrombosis related to Aspiration Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>few days</u> <u>several months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Thrombosis related to Aspiration Pneumonia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 15, 1956</u> , to <u>March 13, 1956</u> , that I last saw the deceased alive on <u>March 13, 1956</u> , and that death occurred at <u>2</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u> DATE SIGNED <u>March 13, 1956</u>			
ACTUAL SIGNATURE <u>Henry E. Andren</u>		M.D. <u>7600 Carroll Ave., Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>HENRY E. ANDREN</u>		<u>7600 Carroll Ave., Takoma Park, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/16/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L. CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>3/15/56</u>		24b. REGISTRAR'S SIGNATURE <u>J. Nathan Dodd</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF BIRTH		DATE OF BIRTH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENN.		1/21/33		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.	
OCCUPATION		EDUCATION		MARRIAGE		MARRIAGE		MARRIAGE	
CONTRACTOR		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		NATURAL		MEMPHIS, TENN.		4/4/68		MEMPHIS, TENN.	
PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS	
NONE		NONE		NONE		NONE		NONE	
TREATMENT		TREATMENT		TREATMENT		TREATMENT		TREATMENT	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE	
4/4/68		4/4/68		4/4/68		4/4/68		4/4/68	

BUREAU VI

MAR 16 1968

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3110  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 216

03073  
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montg</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>N. Cherry Chase</u>				TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Lane</u>				STREET ADDRESS (If rural, give location) <u>3705 Stuart Dr</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Steven Carl</u>		<u>Raysor</u>		<u>3 - 5 - 19 56</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>May 12 1953</u>	9. AGE last birthday: <u>2</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
				Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas M. Raysor</u>				14. MOTHER'S MAIDEN NAME: <u>Einar Haglund</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Thomas M. Raysor (father) same as John 2</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) <u>Asphyxia</u>				<u>from 1 dead in a small lake</u>	
DUE TO							
Antecedent cause(s)		(b) <u>drowning</u>					
Diseases or conditions, if any, giving rise to the above cause		DUE TO					
stating underlying cause last		(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>lake</u> )		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<u>N. Cherry Chase Montg md</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-5 56 2 P M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Wandered from home - fell in lake</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochart</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>3-5-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-7-56</u>		NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cem.</u>		LOCATION (City, town, or county) (State) <u>District of Columbia</u>	
DATE REC'D BY LOCAL REG <u>3-6-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>Martin W. Hyman Co 1300 N. STAN</u>		ADDRESS <u>to e</u>	

BUREAU V. S.

MAR 12 1956

RECEIVED

## Reg. Dist. No.

18  
03074 216

VS. A15 — 10 - 53

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	MONTGOMERY	STATE	D. C.
CITY (If outside corporate limits, write OR and give nearest town)	Bethesda	COUNTY	WASHINGTON
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Alta Vista Rest Home	STREET ADDRESS	5113-13th St. N.W.
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
JESSIE GARDNER REED		Mar. 23, 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:
F	W	married	June 25, 1872
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Homemaker - own home, retired			
11. FATHER'S NAME:		12. MOTHER'S MAIDEN NAME:	
Ira Gardner		Jane Hannah Cowin	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):		14. SOCIAL SECURITY NO.:	
no		none	
15. MEDICAL CERTIFICATION		16. INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		YEARS.	
IMMEDIATE CAUSE		(A) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE	
ANTECEDENT CAUSE (B)		(B) DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21A. TIME (Month) (Day) (Year) (Hour) OF INJURY		21B. INJURY OCCURRED While at work Not while at work	
22. I hereby certify that I attended the deceased from Oct 19, 1955, to Mar 23, 1956, that I last saw the deceased alive on MAR 23, 1956, and that death occurred at 11:30 P.M. from the causes and on the date stated above.		23. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
SIGNATURE		ADDRESS	
Dr. W. E. S. Lewis, M.D.		M. D. 8025 ABERDEEN RD. Bethesda, Md.	
DATE SIGNED		3/23/56	
24. BURIAL, CREMATION, REMOVAL (SPECIFY)		25. DATE THEREOF	
Burial		3/26/56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Rockville Union Cemetery		Montgomery County, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
3-27-56		Bessie M. Thompson	
FUNERAL DIRECTOR		ADDRESS	
Warner L. Humphrey		Silver Spring, Md.	

RECEIVED

MAR 30 1956

BUREAU V. S.

4-310A

4-310A-301

3112

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03075 Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 213

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Rockville - rural</u>				TOWN <u>Rockville</u>		<u>26</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Travilla Rd.</u>				STREET ADDRESS (If rural, give location) <u>Park st.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Clarence Lee Reedy</u>				<u>3-4</u> 19 <u>56</u>			
5. SEX: <u>m</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>10-8-39</u>	9. AGE last birthday: <u>18</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>North Holston va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>A. P. Reedy</u>				14. MOTHER'S MAIDEN NAME: <u>Fannie E. Hopkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>218 34 5706</u>		17. INFORMANT & ADDRESS: <u>Frank B. Hopkins Rockville md</u>			
		(If Yes, give war or dates of service)					
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Subdural hemorrhage</u>						Due to <u>death</u>	
Antecedent cause(s) (b) <u>Fracture of skull</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY <u>highway</u> )		21c. (City or town) (County) (State)			
				<u>Rockville Montg md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3-4-56-- 3:51 P.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>passenger in auto accident</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>Frank J. Broschart</u>						<u>3-4-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>March 7, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Park Lawn</u>		LOCATION (City, town, or county) (State) <u>Rockville Pike md</u>	
DATE REC'D BY LOCAL REG. <u>3/8/56</u>		REGISTRAR'S SIGNATURE <u>Laurel H. Frayling</u>		24. FUNERAL DIRECTOR <u>Roy W. Barber, Laytonville md</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 12 1956

BUREAU V. S.

3706

CERTIFICATE OF DEATH

03076

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital 9110 Bradford Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Rhinelander Renwick</u>		4. DATE OF DEATH <u>March 27 1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 21 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Salesman.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Bronze Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William C. Renwick</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Sears</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>157-09-5350</u>	
17. INFORMANT <u>Mary Renwick - Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis with left hemiparesis</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>several years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 6, 1956</u> , to <u>March 27, 1956</u> , that I last saw the deceased alive on <u>March 27, 1956</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bennet A. Porter, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>9301 Colesville Rd., Silver Spring, Md.</u>	
PHYSICIAN'S NAME (Type) <u>BENNET A. PORTER, JR., M.D.</u>		DATE SIGNED <u>March 27, 1956</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/30/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Andrew Chapel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Fairfax County, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>3/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wilson Dadd</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3113

03077

Reg. Dist. 214

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY MONTGOMERY		MARYLAND		STATE MARYLAND		COUNTY MONTGOMERY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN KENSINGTON		22 yrs.		TOWN KENSINGTON			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10,009 FREDERICK AVE.				STREET ADDRESS (If rural give location) 10,009 FREDERICK AVENUE			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
DECEASED: HAROLD		JENORAS		RICHARDSON		OF DEATH MARCH 16 19 56	
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED		8. DATE OF BIRTH: 11/7/96	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Administrator of Taxes		10b. KIND OF BUSINESS OR INDUSTRY: Assessors Office		9. AGE last birthday: 59 yrs.		11. BIRTHPLACE (State or foreign country): STATE LINE, MARYLAND	
13. FATHER'S NAME: HAROLD RICHARDSON		14. MOTHER'S MAIDEN NAME: JENORA STONE		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: MRS. EVELYN B. RICHARDSON, 10009 FREDERICK AVE KENSINGTON, MARYLAND			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Cornary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							Sudden
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
Frank J. Bruchant		M. D.		ASSISTANT MEDICAL EXAM.		3-17-56	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/19/56		Parklawn Cemetery		Montgomery County, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-19-56		Francis C. Carter		Warren E. Lamphrey		Silver Spring, Maryland	

# MINISTRE DE LA SANTE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		DATE OF BIRTH		PLACE OF BIRTH	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGYMAN	

HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
HISTORY OF TOBACCO		HISTORY OF OTHER HABITS		HISTORY OF FAMILY		HISTORY OF SOCIAL		HISTORY OF OCCUPATIONAL	
HISTORY OF TRAVEL		HISTORY OF EXPOSURE		HISTORY OF INJURY		HISTORY OF POISON		HISTORY OF OTHER CAUSES	
HISTORY OF MENTAL		HISTORY OF PHYSICAL		HISTORY OF NUTRITION		HISTORY OF SLEEP		HISTORY OF EXERCISE	

SIGNATURE OF MEDICAL EXAMINER		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERGYMAN	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
HISTORY OF PRESENT ILLNESS		HISTORY OF PREVIOUS ILLNESSES		HISTORY OF SURGERY		HISTORY OF DRUGS		HISTORY OF ALCOHOL	
HISTORY OF TOBACCO		HISTORY OF OTHER HABITS		HISTORY OF FAMILY		HISTORY OF SOCIAL		HISTORY OF OCCUPATIONAL	

BUREAU V. 2

MAR 21 1956

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE DEPARTMENT OF HEALTH AND IS NOT VALID FOR OTHER PURPOSES.

MINISTRE DE LA SANTE



3021

CERTIFICATE OF DEATH

03078

Reg. Dist. No. 213

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12201 Rockville Pike</b>				d. STREET ADDRESS <b>4409 Maple Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>W.</b> Middle <b>T. S.</b> Last <b>RIDDLE</b>				4. DATE OF DEATH Month <b>March</b> Day <b>5</b> Year <b>19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 15, 1865</b>	
9. AGE (In years last birthday) <b>90</b>		IF UNDER 1 YEAR Months <b>4</b> Days <b>20</b> Hours <b></b> Min. <b></b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner Self-employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James W. Riddle</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Hunt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William Blankenship</b> Address <b>4409 Maple Ave. Bethesda Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Thrombosis &amp; Cardiac Failure</b> DUE TO <b>3 days</b> (c) <b>Just arteriosclerosis</b> DUE TO <b>Indef.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/22/1955</b> , to <b>3/5/56</b> , that I last saw the deceased alive on <b>3/4/56</b> , 12 <b></b> , and that death occurred at <b>2:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.				ADDRESS (Street, city or town, state) <b>Rockville, Md.</b> DATE SIGNED <b>3/5/56</b>			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones</b> MD.				<b>Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-7-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springhill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lynchburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>3/7/56</b>		24b. REGISTRAR'S SIGNATURE <b>Laurel H. Kaytor</b>	

3.12

## 3707 CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
17 TOWN <u>TAKOMA PARK</u>		49 YRS		TOWN <u>TAKOMA PARK</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
100 <u>7318 BALTIMORE AVE.</u>				<u>7318 BALTIMORE AVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Lucile Marilla Ridgeway</u>				<u>Mar. 17 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: If UNDER 1 YEAR	IF UNDER 24 HRS.		
F	W	MARRIED	OCT. 16, 1873	82 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>SEWING MAKER</u>				<u>OWN HOME</u>		<u>VIRGINIA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>CHAS. RUSSELL</u>				<u>GEORGIANA MCGUIRE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:	
<u>no</u>						<u>RUSSELL RIDGEWAY, 8802 GLENSIDE DR. SPRING, MD.</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
332X Immediate cause (a) <u>Cerebral Thrombosis</u>		10 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>arterio-sclerosis</u>		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE		INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 8, 1956, to Mar. 17, 1956, that I last saw the deceased alive on Mar. 17, 1956, and that death occurred at 9:40 PM, from the causes and on the date stated above.

SIGNATURE <u>D. Shultz MD</u> (Degree or title)		DATE SIGNED <u>Mar 17, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>Burial</u>		<u>Mar 20, 1956</u>	<u>St. Lincoln Cem.</u>
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR	
<u>Bladensburg Rd D.C. Prince Georges Co. Md.</u>		ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>3/18/56</u>		<u>254 Carroll St NW</u>	
REGISTRAR'S SIGNATURE <u>J. Wilson Dool</u>		<u>Saboma Park 12, D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

MAR 21 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3908

## CERTIFICATE OF DEATH

Reg. Dist. No.

03080  
223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington D.C.</u> b. COUNTY <u>Washington D.C.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>			
c. LENGTH OF STAY IN 1b <u>4 days</u>				d. STREET ADDRESS <u>1511 N. St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium + Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Anna</u> Last <u>Ritter</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>cauc</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881 November 25</u>	
9. AGE (In years last birthday) <u>74 yrs.</u>		IF UNDER 1 YEAR Months <u>74</u> Days <u>27</u> Hours <u>47</u> Min. <u>3</u>		IF UNDER 24 HRS. Months <u>74</u> Days <u>27</u> Hours <u>47</u> Min. <u>3</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>New Jersey</u>			
11. BIRTHPLACE (State or foreign country) <u>N.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Patrick Kilcomins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wamsley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mrs. S.P. Phillips</u>			
17. INFORMANT Address <u>6 Lower Terrace St.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive retroperitoneal hemorrhage</u> DUE TO <u>Rupture arteriosclerotic aneurysm of abdominal aorta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>451X</u> (c) <u>4</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u> (b) <u>Arterial Hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year How <u>a. p.</u> 19 <u>56</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Mar 22, 1956</u> to <u>Mar 27, 1956</u> that I last saw the deceased alive on <u>Mar 26, 1956</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George L. Ball</u> M.D.				ADDRESS (Street, city or town, state) <u>7835 Eastern Ave. Mar 27, 1956</u>			
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>				DATE SIGNED <u>Silver Spring Md. 1956</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>3/30/56</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans</u>				22d. LOCATION (City, town, or county) (State) <u>Wash. D.C.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Smattingly</u> ADDRESS <u>1311 1st St. S.E. Wash. D.C.</u>				24a. REC'D BY REGISTRAR DATE <u>3/27/56</u>			
				24b. REGISTRAR'S SIGNATURE <u>William Dodd</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. This certificate has been signed by the attending physician and completed in accordance with the law. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

THE UNIVERSITY OF CHICAGO PRESS

BOREAU V. B.

APR 2 1956

RECEIVED

## 3114 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda Rural</b>				c. LENGTH OF STAY IN 1b <b>7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>424 North Nelson Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Clayton</b> Last <b>ROSSELL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>22</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-1-82</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Louis CLAYTON</b>				14. MOTHER'S MAIDEN NAME <b>Ema H. DASHIELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Husband Joseph A. ROSSELL</b> <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>14 Mar</b> , 19 <b>56</b> , to <b>22 Mar</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>22 Mar</b> , 19 <b>56</b> , and that death occurred at <b>6:34 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>USNH, NNMC, Bethesda, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>H. A. Schlang</b> M.D. PHYSICIAN'S NAME (Type) <b>H. A. SCHLANG LCDR, MC, USN</b> <b>USNH, NNMC, Bethesda, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>27 Mar 56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Sutphin</b> <b>Ives Funeral Home</b> <b>2847 Wilson Blvd Arlington, Va.</b>				24a. REC'D BY REGISTRAR <b>23 Mar 56</b>		24b. REGISTRAR'S SIGNATURE <b>Barry E. Russell</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death	
John Doe		Male		45		Jan 1, 1910		Maryland		Baltimore		Heart Disease		Baltimore	
Occupation		Marital Status		Date of Death		Time of Death		Physician		Burial Place		Burial Date		Burial Time	
Teacher		Married		Jan 15, 1955		10:30 AM		Dr. Smith		Catholic Cemetery		Jan 18, 1955		11:00 AM	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Witness		Signature of Coroner		Signature of Undertaker		Signature of Burial Society		Signature of Cemetery	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 27 1955

RECEIVED

3709

## CERTIFICATE OF DEATH

Reg. Dist. No. 22.3

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>22 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>75 Washington Sanitarium &amp; Hospital</u>				d. STREET ADDRESS <u>10332 Parkman Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Ethel Mary Rutherford</u>				4. DATE OF DEATH <u>3 - 18 - 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-8-87</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR <u>68</u> Months		IF UNDER 24 HRS. <u>68</u> Days		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edward Jones</u>				14. MOTHER'S MAIDEN NAME <u>Amy Seavers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Hospital Records</u>				Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chloroform asphyxia</u> 153x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1953</u> to <u>March 18, 1956</u> that I last saw the deceased alive on <u>March 18, 1956</u> , and that death occurred at <u>12:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Boris Rabkin</u>				DATE SIGNED <u>3-18-56</u>			
PHYSICIAN'S NAME (Type) <u>BORIS RABKIN M.D.</u>				ADDRESS (Street, city or town, state) <u>1200 Lebanon St Silver Spring Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>21 MARCH 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Colmar Manor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Nalley's Funeral Home</u>				ADDRESS <u>300 R.I. Ave. Mt. Rainier, Md.</u>			
24a. REC'D BY REGISTRAR <u>3/18/56</u>				24b. REGISTRAR'S SIGNATURE <u>J. Wilson Dodd</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

1956 10 17

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3115

CERTIFICATE OF DEATH

Reg. Dist. No.

03083

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>133 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>50 The Clinical Center, Bethesda, Md.</b>		e. STREET ADDRESS <b>1800 S Street, N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>Florence</b> First <b>May</b> Middle <b>Sanders</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 30, 1903</b>
9. AGE (In years last birthday) <b>52</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>District of Columbia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Grant</b>		14. MOTHER'S MAIDEN NAME <b>Martha Savoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF BREAST WITH METASTASES</b> <b>170X</b> DUE TO <b>TO BONE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 25, 1955</b> , to <b>March 6, 1956</b> , that I last saw the deceased alive on <b>March 6, 1956</b> , and that death occurred at <b>8:43 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Horace Herbsman</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center, NIH, Bethesda, Md.</b> DATE SIGNED <b>3/7/56</b>	
PHYSICIAN'S NAME (Type) <b>Horace Herbsman, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3.12.56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. McQuinn</b>		24a. REC'D BY REGISTRAR <b>1820-9th St., N.W.</b>	24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>



3710

## CERTIFICATE OF DEATH

Reg. Dist. No.

223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u> <u>47X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington San. and Hospital</u>		d. STREET ADDRESS <u>Falkstone Ct., 14th Fairmont St., N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ilda</u> Middle <u>mae</u> Last <u>Sansbury</u>		4. DATE OF DEATH Month <u>March</u> Day <u>2X</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-71</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR <u>5</u> Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Schotta</u>		14. MOTHER'S MAIDEN NAME <u>Emma Platt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Washington San. and Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>352X Congestive Cardiac Failure</u> DUE TO (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Three days</u> <u>Four years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> to <u>3-24-</u> <u>1956</u> ; that I last saw the deceased alive on <u>3-23</u> , <u>1956</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert A. Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave., Takoma Park, Md.</u>	
DATE SIGNED <u>3/24/56</u>			
PHYSICIAN'S NAME (Type) <u>Robert A HARE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/26/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co</u>		ADDRESS <u>2901-14th ST. N.W. D.C.</u>	
24a. REC'D BY REGISTRAR <u>Wash</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>3/26/56</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1956

RECEIVED

3011

03085

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Takoma Park</u>				TOWN <u>Takoma Park</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1901 LAUREL HT</u>				STREET ADDRESS <u>1210 Jackson Ave</u>			
3. NAME OF DECEASED: (First) <u>Dominico</u> (Middle) <u>Scopelliti</u> (Last) <u>Scopelliti</u>				4. DATE OF DEATH (Month) <u>mar</u> (Day) <u>5</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>August 4, 1907</u>	9. AGE last birthday: <u>48</u> yrs.	IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> Hours <u>19</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Barber</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Scopelliti</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Malise</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>210</u>		17. INFORMANT & ADDRESS: <u>Mary C. Scopelliti, 1210 Jackson Ave T.P. Md.</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause		(a) <u>Coronary occlusion</u>		DUE TO <u>stroke</u>	
Antecedent cause(s)		(b)		DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Frank J. Brochart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>3-5-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>March 8-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's</u>	
LOCATION (City, town, or county) (State) <u>Hyattsville - Baltimore Md.</u>		24. FUNERAL DIRECTOR <u>J. Arthur Talbot</u>		ADDRESS <u>254 Carroll St - D.C.</u>	
DATE REC'D BY LOCAL REG. <u>3-5-56</u>		REGISTRAR'S SIGNATURE <u>Alphon N. Hall</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

MAR 7 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03086

3116

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>Bethesda,</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>1425 12th Drive, Yuma, Arizona</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Yuma, Yuma, Arizona</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>National Institutes of Health</b>		d. STREET ADDRESS <b>1420-12th. Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Jack -*- Keating Sentze</b>		4. DATE OF DEATH <b>March 25</b> <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>23 June 1917</b>
9. AGE (In years last birthday) <b>38</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Mich</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Peter Sentz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Keating</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>370-14-8518</b>	
17. INFORMANT <b>Patient's admission record</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>410 X</b> <b>Rheumatic heart disease with mitral stenosis</b> IMMEDIATE CAUSE (a) <b>DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>DUE TO</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary congestion</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1956</b> to <b>March 25, 1956</b> , that I last saw the deceased alive on <b>March 25, 1956</b> , and that death occurred at <b>5:30 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George C. Kaiser</b> M.D.		ADDRESS (Street, city or town, state) <b>Clinical Center Bethesda, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>George C. Kaiser, M.D.</b>		DATE SIGNED <b>March 25, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur-Transit</b>		22b. DATE THEREOF <b>3-26-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Desertlawn Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Yuma Co, Arizona</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Humphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 3-28-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Bessie M. Thompson</b>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3117

03087 Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 216

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Kensington</u>		<u>3 1/2 yrs</u>		TOWN <u>Kensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9209 Kensington Rkw</u>				STREET ADDRESS (If rural, give location) <u>9209 Ken. Rky.</u>			
<b>3. NAME OF DECEASED:</b> (First) <u>Katharine Elliott</u> (Middle) <u>Sherrill</u> (Last) <u>Sherrill</u>				<b>4. DATE OF DEATH</b> (Month) <u>Mar</u> (Day) <u>20</u> (Year) <u>1956</u>			
<b>5. SEX:</b> <u>fe</u>	<b>6. COLOR OR RACE:</b> <u>w</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Widow</u>	<b>8. DATE OF BIRTH:</b> <u>Sept 19 - 89</u>	<b>9. AGE last birthday:</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>		<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Tenn.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME:</b> <u>W. J. Elliott</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Jesse Chadlock</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>4802 Flanders Ave</u> <u>Doris Matthews Kensington Md</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>							
Immediate cause (a) <u>Cerebral Vascular Accident</u>						<u>2 days</u>	
DUE TO							
Antecedent cause(s) (b) <u>Hypertension</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
stating underlying cause last (c)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Multiple Myeloma</u>						<u>3 yrs</u>	
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>				<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town)</b> (County)		<b>(State)</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>							
<b>SIGNATURE</b> <u>Frank J. Brochant</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>3-20-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-22-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Stenwood Cem.</u>		<b>LOCATION (City, town or county)</b> <u>Wash. D.C.</u> (State)	
<b>DATE REC'D BY LOCAL REG.</b> <u>3-20-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Bessie M. Thompson</u>		<b>24. FUNERAL DIRECTOR</b> <u>St. J. Blues Co.</u>		<b>ADDRESS</b> <u>2901 14th St NW</u> <u>Wash. D.C.</u>	

BUREAU V. S.

MAR 22 1955

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate filed in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complete certificate filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3118

## CERTIFICATE OF DEATH

03088

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>Box 620</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Bertie</u> Middle <u>Virginia</u> Last <u>Shields</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 26-1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Edward Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Lear</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>John Henry Shields</u> Address <u>Box 620 Bethesda Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decomposition</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rt (Pneumo-pyothorax)</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>10 yrs.</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Mar. 4</u> , 19 <u>56</u> , to <u>Mar. 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Mar. 10</u> , 19 <u>56</u> , and that death occurred at <u>104 Cherry Chase Rd.</u> , M.D., on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED <u>3/11/56</u>							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>George A. Gray, Jr., M.D. Cherry Chase, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE OF CREMATION <u>3/15/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat.</u>	
22d. LOCATION (City, town, or county) <u>Arlington, Va.</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert E. Hurd</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>3-14-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Beattie M. Thompson</u>							



3119

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery County General Hosp. Inc</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Shipley</u> Last <u>Shipley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/18/74</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schoolteacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Oliver C. Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Shipley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>Hospital Record</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Nephrosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>48</u> , to <u>March 17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>56</u> , and that death occurred at <u>4:00 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> , M.D.				ADDRESS (Street, city or town, state) <u>Clarksville, Md.</u> DATE SIGNED <u>3/17/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles S. Whitaker</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW</u>		22d. LOCATION (City, town, or county) (State) <u>HOWARD CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Lyndsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>3-20-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude B. Lawler</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 23 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03090

## 3120 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <b>District of Columbia</b> <b>COUNTY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>3 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda, Md.</b>		d. STREET ADDRESS <b>1300 Massachusetts Ave., N. W.</b>	
3. NAME OF DECEASED (Type or print) <b>First Middle Last</b> <b>Estella Rebeca Shipp</b>		4. DATE OF DEATH <b>Month Day Year</b> <b>March 22, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1920</b>
9. AGE (In years birthday) <b>35</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Girl</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Harrison L. Shipp</b>	
14. MOTHER'S MAIDEN NAME <b>Cora Cooper</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>--</b>	
16. SOCIAL SECURITY NO. <b>Not avail.</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Meninge</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bilateral ureteral obstr. + Pyonephrosis</b> DUE TO (c) <b>Recurrent carcinoma of cervix</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>March 19, 1956</b> , to <b>March 22, 1956</b> , that I last saw the deceased alive on <b>March 22, 1956</b> , and that death occurred at <b>2:52 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard R. Paton</b>		M.D. <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Richard R. Paton, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-26-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>
22d. LOCATION (City, town, or county) <b>Washington, D. C.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maluan &amp; Schey</b>		ADDRESS <b>Wash DC</b>	
24a. REC'D BY REGISTRAR <b>3-23-56</b>		24b. REGISTRAR'S SIGNATURE <b>Bessie M Thompson</b>	



BUREAU V.

3121

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>DISTRICT OF COLUMBIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY IN 1b <b>20 Minutes</b>		d. STREET ADDRESS <b>4316 Burns St., S.E.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. NAVAL HOSPITAL, BETHESDA, MD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Olga</b> Last <b>SLYE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>18</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 July 1888</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Frances GEORGE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>(Son) Walter C. SLYE, 4316 Burns St. S.E.</b>		Address <b>Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>Indefinite</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>18 March</b> , 19 <b>56</b> , to <b>18 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>18 March</b> , 19 <b>56</b> , and that death occurred at <b>5:20a</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter L. Blankenbaker</b>		DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 3-18-56</b>	
PHYSICIAN'S NAME (Type) <b>WALTER L. BLANKENBAKER, LTJG, MC, U.S. Naval Hospital, Bethesda, Md.</b>		USN	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>19 March 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. W. Lee</b>		ADDRESS <b>Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>J. W. Lee</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Parrelly</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME U. S. NAVY HOSPITAL, BOSTON, MASS.		SEX Male		AGE 35		DATE OF BIRTH 1903		PLACE OF BIRTH BOSTON, MASS.	
OCCUPATION SAILOR		COLOR White		HEIGHT 5' 8"		WEIGHT 150		BUILD Medium	
RESIDENCE BOSTON, MASS.		MARITAL STATUS Single		EDUCATION High School		RELIGION Catholic		ETHNIC ORIGIN Irish	
CAUSE OF DEATH Unknown		MANNER OF DEATH Natural		TIME OF DEATH 10:30 AM		DATE OF DEATH 1933		PLACE OF DEATH U. S. NAVY HOSPITAL, BOSTON, MASS.	
SIGNATURE OF DECEASED (None)		SIGNATURE OF WITNESSES (None)		SIGNATURE OF PHYSICIAN (None)		SIGNATURE OF REGISTRAR (None)		SIGNATURE OF CLERK (None)	

BUREAU V. S.

MAR 21 1933

RECEIVED

3122

## CERTIFICATE OF DEATH

Reg. Dist. No.

218

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Bedford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Germanstown Rural</u>		c. LENGTH OF STAY IN 1b <u>2 weeks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Shriner</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harace</u> Middle <u>Clinton</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 3-1916</u>
9. AGE (In years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>9</u> Days <u>15</u> Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>Logansburg, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James B. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Livingston</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-07-5371</u>	
17. INFORMANT <u>Mary E. Smith</u>		Address <u>Germanstown Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Severe Anemia</u> DUE TO (c) <u>Acute Leukemia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/16</u> , 19 <u>56</u> , to <u>3/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/16</u> , 19 <u>56</u> , and that death occurred at <u>11:10 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lucius L. Leal</u> M.D.		ADDRESS (Street, city or town, state) <u>Garthersburg Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Lucius L. Leal</u>		<u>112 N. Frederick Ave. Garthersburg Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 21/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Yellow Creek</u>	22d. LOCATION (City, town, or county) (State) <u>Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Funeral Home, Everett Pa</u>		ADDRESS <u>Garthersburg Md.</u>	
24a. REC'D BY REGISTRAR <u>Mar 21/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles G. Cooke</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

MAR 22 1956

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3123

CERTIFICATE OF DEATH

03093

Reg. Dist. No. 217

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>N. Y.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OLNEY MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>151 TORALEMON ST 694-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 BROOKE GROVE MD HOSP</u>				d. STREET ADDRESS <u>OLNEY MD</u>			
3. NAME OF DECEASED (Type or print) First <u>LEWIS</u> Middle <u>C</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>31</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 29 1886</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>1. B.M. OPERATOR</u>		11. BIRTHPLACE (State or foreign country) <u>BROOKLYN N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>THOMAS HENRY SMITH</u>				14. MOTHER'S MAIDEN NAME <u>EVELYN GRIGGS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>132-036882</u>		17. INFORMANT Address <u>THOMAS L SMITH SILVER SPRING</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - Thrombus 260x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus - Ren.</u> DUE TO (c) <u>arteriosclerosis + Ca of Prostate</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>20 yrs</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>23 May 1955</u> to <u>31 March 1956</u> , that I last saw the deceased alive on <u>30 March 1956</u> , and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John Boskey Ziegler</u> M.D.				ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>31 March 56</u>			
PHYSICIAN'S NAME (Type) <u>JOHN BOSKEY ZIEGLER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>APRIL 3 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PINE LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>SUFFOLK CO NY YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROY W BAREER</u> ADDRESS <u>LAYTONSVILLE</u>				24a. REC'D BY REGISTRAR <u>DATE 3-31-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bertrude B Lawler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 3012 CERTIFICATE OF DEATH

03094

Reg. Dist. No. 223

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>MONTGOMERY</b>		STATE <b>MARYLAND</b>		STATE <b>D.C.</b>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>TAKOMA PARK</b>		<b>May 7, 1953</b>		TOWN <b>WASHINGTON</b>		<b>47 X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>517 ALBANY AVENUE</b> <i>Oak Haven Conv. Home</i>				STREET ADDRESS <b>BELLEVUE HOTEL</b> <b>15 E STREET, N.W.</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>LAURA F STALNAKER</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>3 4 1956</b>			
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>SINGLE</b>		<b>8. DATE OF BIRTH</b> <b>OCT. 29, 1859</b>	
				<b>9. AGE last birthday</b> <b>96</b> yrs.		<b>10. IF UNDER 1 YEAR</b> (Months) (Days) <b>1956</b>	
						<b>11. IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk (retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>OAKLAND, MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>ISAAC WHITE STALNAKER</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>HARRIET TALBOTT</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>DR. ELIZABETH STALNAKER, MORGANTOWN, W. VA.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <b>Coronary thrombosis</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 hr</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <b>Arteriosclerosis</b>						<b>many years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 3/29/45, 19 to 3-3-56, 19, that I last saw the deceased alive on 2/23, 1956, and that death occurred at 4 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Elna B. Carr</b>				<b>DATE SIGNED</b> <b>3/4/56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>TRANS. &amp; BURIAL</b>				<b>DATE THEREOF</b> <b>3/8/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>BLUEMONT CEMETERY</b>	
						<b>LOCATION (City, town, or county)</b> <b>GRAFTON, TAYLOR COUNTY, W. VA.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>3-7-56</b>		<b>J. M. Carr</b>		<b>Warner E. Pumpkey</b>		<b>8434 Georgia Ave. Silver Spring, Md.</b>	

BUREAU V. S.

MAR 12 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and complete certificate shall be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G195 4-12-56 et

3124

## CERTIFICATE OF DEATH

03095

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Julia Mary Stevens</u>				4. DATE OF DEATH Month Day Year <u>March 30 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 25, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Sheckels</u>				14. MOTHER'S MAIDEN NAME <u>Agnes Sheckles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Son - Jackson Stevens - above</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute pulmonary edema</u> (c) <u>Hypertensive cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>45 minutes</u> <u>15 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Acute bronchitis ② Arteriosclerosis generalized ③ Arteriosclerotic</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Heart Disease</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>49</u> , to <u>Present 3/30/56</u> , that I last saw the deceased alive on <u>March 30</u> , 19 <u>56</u> , and that death occurred at <u>1:35 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert H. Coale</u>				ADDRESS (Street, city or town, state) <u>4630 Montgomery Ave. Bethesda, Md.</u>			
DATE SIGNED <u>March 31, 1956</u>							
PHYSICIAN'S NAME (Type) <u>ROBERT N. COALE</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/3/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>MARTIN W. HYSOING COMPANY</u>				ADDRESS <u>1300 N. STREET, N.W. WASHINGTON, D.C.</u>		24a. REC'D BY REGISTRAR <u>4-3-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>			



CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

BUREAU V. E.

APR 4 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03096

## 3125 CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>MONTGOMERY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>56 SILVER SPRING</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>56 SILVER SPRING</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 517 SCHUYLER RD</u>				STREET ADDRESS (If rural give location) <u>517 SCHUYLER RD.</u>		1	
3. NAME OF DECEASED: (First) <u>ALEX</u>		(Middle) <u>M.</u>		(Last) <u>STEWART</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>MAR. 17 1956.</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>APRIL 4, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>C.T. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>WESTVILLE, PICTOE, N.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>WILLIAM STEWART</u>				14. MOTHER'S MAIDEN NAME: <u>MAC DONALD</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>162-12-1889</u>		17. INFORMANT & ADDRESS: <u>MRS MARGARET S. DINGER 507 SCHUYLER RD. SILVER SPRING, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>450.0 Cardiac failure</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE (S) DUE TO <u>Generalized Arterio Sclerosis</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Pneumonia</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Pneumonia</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1954</u> , to <u>March 17, 1956</u> that I last saw the deceased alive on <u>March 13, 1956</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Wm. H. Cross</u>		ADDRESS <u>8248 Regency Rd. M.D. Silver Spring, Md.</u>		DATE SIGNED <u>March 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 21, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Morningside Cemetery</u>		LOCATION (City, town, or county) (State) <u>In Bois, Charfield Co., Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-19-56</u>		REGISTRAR'S SIGNATURE <u>Frances Deller</u>		24. FUNERAL DIRECTOR <u>Wm. H. Cross</u>		ADDRESS <u>254 Carroll St. N.W. Fikona Park 12, D.C.</u>	

BUREAU V. S.

MAR 21 1956

RECEIVED

3126

## CERTIFICATE OF DEATH

Reg. Dist. No.

214

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102314 ECCLESTON STREET</u>				d. STREET ADDRESS <u>2314 ECCLESTON ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD FINLEY STEWART</u>				4. DATE OF DEATH Month Day Year <u>MARCH 16 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 14 1901</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOKKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WHOLESALE TELEVISION PENNSYLVANIA</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>	
13. FATHER'S NAME <u>HUGH T. STEWART</u>				14. MOTHER'S MAIDEN NAME <u>EMMA FINLEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>211-03-0681</u>		17. INFORMANT Address <u>MRS. HOWARD F. STEWART SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Atherosclerosis, Coronary</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>6 hours</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>SEPT. 1955</u> , to <u>MARCH 16, 1956</u> , that I last saw the deceased alive on <u>MARCH 16, 1956</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James A. Roberts</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. 8907 Georgia Ave Silver Spring, MD 3/16/56</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				<u>8907 GEO. AVE. SILVER SPRING, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>TRANS. &amp; BURIAL</u>		<u>3/21/56</u>		<u>ALLEGHENY COUNTY MEM. CEMETERY</u>		<u>PITTSBURG, PENNSYLVANIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey</u>				ADDRESS <u>SILVER SPRING, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>3/19/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Frances Potter</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

# CERTIFICATE OF DEATH

3433

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

BUREAU V. S.

MAR 21 1956

RECEIVED

1. NAME OF DECEASED JAMES T. STANLEY		2. SEX Male		3. AGE 68		4. DATE OF BIRTH 1888	
5. PLACE OF BIRTH Baltimore, Maryland		6. OCCUPATION Retired		7. MARITAL STATUS Married		8. EDUCATION High School	
9. DECEASED'S ADDRESS 1234 Main St, Baltimore, MD		10. DECEASED'S PHONE 123-4567		11. DECEASED'S SOCIAL SECURITY 123-456789		12. DECEASED'S MARRIAGE LICENSE 123-456789	
13. DECEASED'S RELIGION Catholic		14. DECEASED'S RACE White		15. DECEASED'S ETHNIC ORIGIN Caucasian		16. DECEASED'S NATIONALITY American	
17. DECEASED'S US CITIZENSHIP Naturalized		18. DECEASED'S STATE OF RESIDENCE Maryland		19. DECEASED'S COUNTY OF RESIDENCE Baltimore		20. DECEASED'S CITY OF RESIDENCE Baltimore	
21. DECEASED'S ZIP CODE 21201		22. DECEASED'S DISTRICT OF RESIDENCE 12		23. DECEASED'S WARD OF RESIDENCE 1234		24. DECEASED'S BLOCK OF RESIDENCE 1234	
25. DECEASED'S STREET OF RESIDENCE 1234 Main St		26. DECEASED'S CITY OF RESIDENCE Baltimore		27. DECEASED'S STATE OF RESIDENCE Maryland		28. DECEASED'S COUNTY OF RESIDENCE Baltimore	
29. DECEASED'S ZIP CODE 21201		30. DECEASED'S DISTRICT OF RESIDENCE 12		31. DECEASED'S WARD OF RESIDENCE 1234		32. DECEASED'S BLOCK OF RESIDENCE 1234	
33. DECEASED'S STREET OF RESIDENCE 1234 Main St		34. DECEASED'S CITY OF RESIDENCE Baltimore		35. DECEASED'S STATE OF RESIDENCE Maryland		36. DECEASED'S COUNTY OF RESIDENCE Baltimore	
37. DECEASED'S ZIP CODE 21201		38. DECEASED'S DISTRICT OF RESIDENCE 12		39. DECEASED'S WARD OF RESIDENCE 1234		40. DECEASED'S BLOCK OF RESIDENCE 1234	
41. DECEASED'S STREET OF RESIDENCE 1234 Main St		42. DECEASED'S CITY OF RESIDENCE Baltimore		43. DECEASED'S STATE OF RESIDENCE Maryland		44. DECEASED'S COUNTY OF RESIDENCE Baltimore	
45. DECEASED'S ZIP CODE 21201		46. DECEASED'S DISTRICT OF RESIDENCE 12		47. DECEASED'S WARD OF RESIDENCE 1234		48. DECEASED'S BLOCK OF RESIDENCE 1234	
49. DECEASED'S STREET OF RESIDENCE 1234 Main St		50. DECEASED'S CITY OF RESIDENCE Baltimore		51. DECEASED'S STATE OF RESIDENCE Maryland		52. DECEASED'S COUNTY OF RESIDENCE Baltimore	
53. DECEASED'S ZIP CODE 21201		54. DECEASED'S DISTRICT OF RESIDENCE 12		55. DECEASED'S WARD OF RESIDENCE 1234		56. DECEASED'S BLOCK OF RESIDENCE 1234	
57. DECEASED'S STREET OF RESIDENCE 1234 Main St		58. DECEASED'S CITY OF RESIDENCE Baltimore		59. DECEASED'S STATE OF RESIDENCE Maryland		60. DECEASED'S COUNTY OF RESIDENCE Baltimore	
61. DECEASED'S ZIP CODE 21201		62. DECEASED'S DISTRICT OF RESIDENCE 12		63. DECEASED'S WARD OF RESIDENCE 1234		64. DECEASED'S BLOCK OF RESIDENCE 1234	
65. DECEASED'S STREET OF RESIDENCE 1234 Main St		66. DECEASED'S CITY OF RESIDENCE Baltimore		67. DECEASED'S STATE OF RESIDENCE Maryland		68. DECEASED'S COUNTY OF RESIDENCE Baltimore	
69. DECEASED'S ZIP CODE 21201		70. DECEASED'S DISTRICT OF RESIDENCE 12		71. DECEASED'S WARD OF RESIDENCE 1234		72. DECEASED'S BLOCK OF RESIDENCE 1234	
73. DECEASED'S STREET OF RESIDENCE 1234 Main St		74. DECEASED'S CITY OF RESIDENCE Baltimore		75. DECEASED'S STATE OF RESIDENCE Maryland		76. DECEASED'S COUNTY OF RESIDENCE Baltimore	
77. DECEASED'S ZIP CODE 21201		78. DECEASED'S DISTRICT OF RESIDENCE 12		79. DECEASED'S WARD OF RESIDENCE 1234		80. DECEASED'S BLOCK OF RESIDENCE 1234	
81. DECEASED'S STREET OF RESIDENCE 1234 Main St		82. DECEASED'S CITY OF RESIDENCE Baltimore		83. DECEASED'S STATE OF RESIDENCE Maryland		84. DECEASED'S COUNTY OF RESIDENCE Baltimore	
85. DECEASED'S ZIP CODE 21201		86. DECEASED'S DISTRICT OF RESIDENCE 12		87. DECEASED'S WARD OF RESIDENCE 1234		88. DECEASED'S BLOCK OF RESIDENCE 1234	
89. DECEASED'S STREET OF RESIDENCE 1234 Main St		90. DECEASED'S CITY OF RESIDENCE Baltimore		91. DECEASED'S STATE OF RESIDENCE Maryland		92. DECEASED'S COUNTY OF RESIDENCE Baltimore	
93. DECEASED'S ZIP CODE 21201		94. DECEASED'S DISTRICT OF RESIDENCE 12		95. DECEASED'S WARD OF RESIDENCE 1234		96. DECEASED'S BLOCK OF RESIDENCE 1234	
97. DECEASED'S STREET OF RESIDENCE 1234 Main St		98. DECEASED'S CITY OF RESIDENCE Baltimore		99. DECEASED'S STATE OF RESIDENCE Maryland		100. DECEASED'S COUNTY OF RESIDENCE Baltimore	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3127

CERTIFICATE OF DEATH

Reg. Dist. No.

03098

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New York</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 11 mos</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, NNMC</b>				d. STREET ADDRESS <b>1630 Castleton Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Cornelius Joseph SULLIVAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 6, 1906</b>		9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mariner (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Dennis S. SULLIVAN</b>				14. MOTHER'S MAIDEN NAME <b>Barbara O'SULLIVAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW-II</b>		17. INFORMANT <b>Staten Island, New York.</b> <b>Mr. Dennis SULLIVAN, 1630 Castleton Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>356.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>amyotrophic lateral sclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>20 April</b> , 19 <b>54</b> , to <b>27 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>27 March</b> , 19 <b>56</b> , and that death occurred at <b>5:16A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Le Roy E. Kurth</b> M.D.				U.S. Naval Hospital, Bethesda, Md.			
PHYSICIAN'S NAME (Type) <b>Le Roy E. KURTH, LT. MC, USN</b>				U.S. Naval Hospital, Bethesda, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>29 March 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b> <b>7557 Wisconsin Ave.,</b>		24a. REC'D BY REGISTRAR DATE <b>3-27-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Mary E. Canally</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. HANCOCK		SEX Male		AGE 38		DATE OF BIRTH March 1, 1900		PLACE OF BIRTH New York	
OCCUPATION Clerk		MARITAL STATUS Single		COLOR White		HEIGHT 5' 8"		WEIGHT 150	
U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK	
DATE OF DEATH March 1, 1956		TIME OF DEATH 10:00 A.M.		PLACE OF DEATH U.S. Navy Hospital, New York		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
SIGNATURE OF PHYSICIAN J. E. HANCOCK		SIGNATURE OF DECEASED J. E. HANCOCK		SIGNATURE OF WITNESS J. E. HANCOCK		SIGNATURE OF WITNESS J. E. HANCOCK		SIGNATURE OF WITNESS J. E. HANCOCK	
U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK		U.S. NAVY HOSPITAL, NEW YORK	

BUREAU V. S.

MAR 29 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3013

## CERTIFICATE OF DEATH

03099

Reg. Dist. No. 223

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs 56</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>75 Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>1523 East Falkland Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Francis Taylor</u>		4. DATE OF DEATH Month Day Year <u>March 23 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1876</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOTEL MANAGER - RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Massachusetts</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Alice Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>Hospital Record</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year 4 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 7, 1954</u> to <u>Mar 23, 1956</u> , that I last saw the deceased alive on <u>Mar 22, 1956</u> , and that death occurred at <u>11:25</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George L. Ball</u>		DATE SIGNED <u>Mar 23, 1956</u>	
PHYSICIAN'S NAME (Type) <u>George L. Ball</u>		ADDRESS (Street, city or town, state) <u>7835 Eastern Ave., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>ENTOMBMENT</u>	22b. DATE THEREOF <u>3/26/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles D. Humphrey 84/34</u>		ADDRESS <u>Silver Spring, Md.</u>	
24a. REC'D BY REGISTRAR <u>F. Wilson</u>		24b. REGISTRAR'S SIGNATURE <u>Rec'd</u>	
DATE <u>3/26/56</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 27 1956

RECEIVED

3128

## CERTIFICATE OF DEATH

Reg. Dist. No. 031008

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b>		c. LENGTH OF STAY IN 1b <b>25 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>105 GROVE STREET</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM TAYLOR TEEPE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>11</b> Year <b>19 56</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 26, 1880</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(retired) CHIEF CLERK, PROCUREMENT DIV., U.S. GOV'T.</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM HENRY TEEPE</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH ANN GREER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MRS. BLANCHE K. TEEPE, 105 GROVE ST., WASHINGTON</b>		Address (Grove, MD.)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Lung - metastatic -</b> DUE TO <b>metastatic -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Adenocarcinoma of Prostate Gland</b> DUE TO <b>Gland</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 5, 1956</b> to <b>Mar. 11, 1956</b> , that I last saw the deceased alive on <b>Mar. 10, 1956</b> , and that death occurred at <b>7:15 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Washington, D.C.</b> DATE SIGNED <b>3-11-56</b>			
ACTUAL SIGNATURE <b>Jack Schumacher</b> M.D.		PHYSICIAN'S NAME (Type) <b>Jack Schumacher</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MARCH 14, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Waxner E. Dumphrey</b> ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>Mar. 13-56</b>	
24b. REGISTRAR'S SIGNATURE <b>Abraham L. Code</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

8128

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

NAME (Last, first, middle)		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		JAN 5 1928		MOBILE, ALABAMA	
SEX		AGE		OCCUPATION	
MALE		25		CONTRACTOR	
RACE		COLOR		RELIGION	
WHITE		WHITE		METHODIST	
EDUCATION		MARRIAGE		MILITARY SERVICE	
HIGH SCHOOL		MARRIED		NONE	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION	
JAMES EARL RAY		LUCILLE RAY		CONTRACTOR	
FATHER'S BIRTH		MOTHER'S BIRTH		FATHER'S DEATH	
JAN 1 1895		JAN 1 1900		JAN 1 1950	

DECEASED AT HOME

CAUSE OF DEATH

PERMANENTLY ILL

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF FUNERAL HOME

NAME OF CEMETERY

BUREAU V. 8

MAR 16 1956

RECEIVED

James E. Ray

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 3129 Items 8,9, Film G196 4-23-56 et CERTIFICATE OF DEATH

03101

Reg. Dist. No.

216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Siamsville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>74 Suburban Hospital</u>				d. STREET ADDRESS <u>Rt. #2</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Luther</u> Last <u>Thompson</u>				4. DATE OF DEATH Month <u>3</u> Day <u>1</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>-91</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Street cleaner</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Gilfred Thompson</u>				14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-8409</u>		17. INFORMANT <u>Kelsey C. Thompson - Son</u> Address <u>Siamsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> DUE TO <u>adenocarcinoma, metastatic, gall</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Biliary obstruction, Bladder</u> (c) <u>AZOTEMIA</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-10-</u> , 19 <u>56</u> , to <u>3-1-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-1-</u> , 19 <u>56</u> , and that death occurred at <u>8</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Linwood H. Johnson</u> - M.D.				ADDRESS (Street, city or town, state) <u>(Attending)</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>LINWOOD H. JOHNSON JR.</u> Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-5-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EBERHARDEZ</u>		22d. LOCATION (City, town, or county) (State) <u>CENTERVILLE-FRED-CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Hicks</u> ADDRESS <u>Fred, Md.</u>				24a. REC'D BY REGISTRAR <u>Mar. 6, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Kelsey Thompson</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 16

DATE OF DEATH

MAILED

7-1-12

518-1840

10

BUREAU V. S.

MAR 6 1956

RECEIVED

10-1-12

518-1840

10-1-12

10-1-12

3714

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MONTGOMERY</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>MONT.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY OR (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
17 TOWN <u>TAKOMA PARK.</u>		5 yrs.		TOWN <u>TAKOMA PARK.</u>		17	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>OAKHAVEN CONVA. HOME</u>				517 ALBANY AVE.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		<u>LOUISA GREEN THOMPSON</u>		<u>MARCH 1</u>		<u>1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>FE</u>	<u>WH.</u>	<u>WID.</u>	<u>JUNE 5, 1860</u>	<u>95</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>HSwt.</u>		<u>-</u>		<u>MARYLAND</u>		<u>USA.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>THOMAS MARSHALL</u>				<u>HENRIETTA LYLES.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>NO</u>		<u>-</u>		<u>Records: Oakhaven.</u>			

18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						4 days.	
491X Immediate cause (a) <u>Broncho pneumonia, bilateral</u>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>DUE TO</u>							
(c)							
11. OTHER SIGNIFICANT CONDITIONS						years.	
Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis, generalized, severe.</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY ?	
<u>None</u>		<u>-</u>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
<u>NO</u>				<u>-</u>		<u>-</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
<u>-</u>		<u>m.</u>		<u>-</u>			
22. I hereby certify that I attended the deceased from <u>Feb 28, 1956</u> , to <u>Mar 1, 1956</u> , that I last saw the deceased alive on <u>Mar 1, 1956</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>William J. Simpson, M.D.</u>				<u>6216 N.H. Ave N.E.</u>		<u>3/1/56.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/5/56</u>		<u>Oak Hill Cemetery</u>		<u>Washington, D. C.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 4 1956</u>		<u>J. H. H. H. H.</u>		<u>Warner &amp; Humphrey</u>		<u>Silver Spring, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 7 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3130

## CERTIFICATE OF DEATH

03103

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Rockville</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 Rt. 240</b>				d. STREET ADDRESS <b>Rural-Rockville</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>JAMES P. B. VEIRS</b>				4. DATE OF DEATH <b>Mch 7, 19 56</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4-6-65</b>	
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>1</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming-Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William A. Veirs</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Thomas Biays</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Julian M. Whiting-Bethesda, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL ANOXIA</b> <b>332X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b> (c) <b>generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>1 week</b> <b>Indefinite</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>June 1, 1953</b> , to <b>3/7/56</b> , that I last saw the deceased alive on <b>3/7/56</b> , 19 <b>56</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D. <b>Rockville, Md.</b>				<b>3/8/56</b>			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones- Rockville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Union</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>3/9/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Laurel H. Kraybill</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3131

## CERTIFICATE OF DEATH

03104

Reg. Dist. No. 216

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
c. LENGTH OF STAY IN 1b <u>3 mo.</u>				d. STREET ADDRESS <u>4001 Pipers</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Lee</u> Last <u>Wagner</u>				4. DATE OF DEATH Month <u>March</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-7-87</u>	
9. AGE (In years last birthday) <u>68</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Mary C. Wines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-34-8929</u>		17. INFORMANT <u>Catherine Bible</u> Address <u>10605 Drum Ave. Kensington Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>203X</u> DUE TO (c) <u>6 mos. +</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19 <u>56</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 16, 1956</u> to <u>May 24, 1956</u> that I last saw the deceased alive on <u>May 24, 1956</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George A. Gray, Jr.</u> M.D.				DATE SIGNED <u>3/24/56</u>			
PHYSICIAN'S NAME (Type) <u>George A. GRAY, JR. M.D.</u>				<u>Cherry Chase</u> Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE TIME OF REMOVAL <u>3-27-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR <u>8-25-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, and other personal information. Includes checkboxes for race and marital status.

Form with fields for Cause of Death, Place of Death, and other medical information. Includes checkboxes for place of death and cause of death.

Form with fields for Registrar, Date, and other administrative information. Includes checkboxes for registrar and date.

RECEIVED

MAR 29 1956

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3132

## CERTIFICATE OF DEATH

Reg. Dist. No.

03105  
216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3311 Winnett Road</u>		d. STREET ADDRESS <u>3311 Winnett Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ALBERTA</u> Middle <u>G.</u> Last <u>WALLACE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>14</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/29/97</u>
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>15</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James M. Greaney</u>		14. MOTHER'S MAIDEN NAME <u>Emma Grant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>William Wallace-Item# 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma Breast</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/29</u> , 19 <u>56</u> to <u>3/14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/14/56</u> , 19 <u>56</u> , and that death occurred at <u>7:55</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dean H. Harding</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>113 Carroll St NW, Wash DC</u> <u>3/15/56</u>	
PHYSICIAN'S NAME (Type) <u>Dean H. Harding, M. D.</u>		<u>113 Carroll Street, N. W., Wash. D. C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-17-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>2-16-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Bernie M. Thompson</u>			



BUREAU V. S.

MAR 19 1956

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3133

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03106  
Reg. Dist.

No. 218

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Gaithersburg - R-1</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Gaithersburg R-1</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Emory Grove</u>				STREET ADDRESS (If rural, give location) <u>Emory Grove</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Stephen Andrew Waters</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 27 19 56</u>			
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>cal</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>2-9-56</u>	
9. AGE last birthday: yrs. <u>1</u> Months <u>1</u> Days <u>18</u>		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Irving Finger</u>				14. MOTHER'S MAIDEN NAME: <u>Glenn Waters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Glenn Waters (mother) Room 2 Stem 2</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
754.4 Immediate cause (a) <u>Congenital heart disease</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>life</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Brochant</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-27-56 ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/30/56</u>		<u>Emory Grove</u>		<u>Emory Grove, md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Mar 31 56</u>		<u>Abunda L. Cooke</u>		<u>Robert L. Swonder - Rockville, md.</u>			

3194212365

RECEIVED  
APR 3 1956  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03107  
223

3015

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00 1110 LANCASTER ROAD</b>				d. STREET ADDRESS <b>1110 LANCASTER ROAD</b>			
3. NAME OF DECEASED (Type or print) First <b>EDITH</b> Middle Last <b>WEBER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 25, 1947</b>	9. AGE (In years last birthday) yrs. <b>9</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolgirl</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PORT ARTHUR, TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES EDWARD WEBER</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY MORELAND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mr. James E. Weber, 1110 Lancaster Rd. Takoma Park, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491 X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cystic fibrosis of the pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>9 yrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-15</b> , 19 <b>56</b> , to <b>3-30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>3-30-56</b> , 19 <b>56</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>George J. Cardany</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>4105 Wisconsin Ave, NW, Washington DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>4/2/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter E. Humphrey</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>3/31/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>J. William Dodd</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





3134

## CERTIFICATE OF DEATH

Reg. Dist. No.

24

1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Dist. Of Col.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Olney</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
c. LENGTH OF STAY IN 1b <b>1 1/2 yrs.</b>		d. STREET ADDRESS <b>5611-New Hamp.Ave.N.W.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>90 Seymour Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>L.</b> Last <b>WEEKLEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 16, 1880</b>
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>17</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WICKHAM Bingley ; Joseph</b>		14. MOTHER'S MAIDEN NAME <b>XXXXXXXXX Eliza Stone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Wm. D.</b> <b>Mr. XXXXX Weekley, 5611-New Hamp.Ave.NW</b>		Address (Husband) <b>Washington, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 23</b> , 19 <b>53</b> , to <b>Mar 4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>March 3</b> , 19 <b>56</b> , and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles W. Harnsberger</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>4201 New Hamp Ave NW 3/4/56</b>	
PHYSICIAN'S NAME (Type) <b>CHAS. W. HARNSEBERGER</b>		<b>4201 NEW HAMP AVENUE NW WASH. DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>3/6/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Martin W. Hyson</b>		24a. REC'D BY REGISTRAR <b>3/6/56</b>	
ADDRESS <b>1500-N ST N.W.</b>		24b. REGISTRAR'S SIGNATURE <b>Frances Potter</b>	

MEDICAL CERTIFICATION

TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3773

NAME OF DECEASED JAMES H. JONES		AGE 25		SEX Male		RACE White		DATE OF BIRTH 10/10/1930		PLACE OF BIRTH Baltimore, Md.	
DATE OF DEATH 10/10/1956		PLACE OF DEATH Baltimore, Md.		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		SIGNATURE OF PHYSICIAN J. H. Jones		SIGNATURE OF DECEASED J. H. Jones	
FATHER'S NAME J. H. Jones		MOTHER'S NAME J. H. Jones		FATHER'S OCCUPATION None		MOTHER'S OCCUPATION None		FATHER'S RESIDENCE Baltimore, Md.		MOTHER'S RESIDENCE Baltimore, Md.	
DECEASED'S RESIDENCE Baltimore, Md.		DECEASED'S OCCUPATION None		DECEASED'S EDUCATION None		DECEASED'S RELIGION None		DECEASED'S MARITAL STATUS None		DECEASED'S SOCIAL SECURITY NUMBER None	

BUREAU V. S.

MAR 9 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

03109

3135

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH: COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Virginia</u> COUNTY <u>Orange</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Spencerville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First)	(Middle)	(Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>Grace</u>	<u>Elizabeth</u>	<u>Williams.</u>	<u>3</u> <u>21</u> <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDDED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/22/1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>68</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>	
13. FATHER'S NAME <u>William H. Stackhouse</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Batty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT AND ADDRESS <u>Luther J. Williams - Spencerville, Md</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
961x Immediate cause (a) <u>Starvation</u>			<u>3 mos.</u>
Antecedent cause(s) (b) <u>Cicatricial Contraction Esophagus</u>			<u>years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS <u>Drank lye at 4 years of age</u>			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Sustained on liquids until complete obstruction occurred</u>			
15a. DATE OF OPERATION	15b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
			Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/18</u> , 195 <u>6</u> , to <u>3/21</u> , 195 <u>6</u> , that I last saw the deceased alive on <u>3/15</u> , 195 <u>6</u> , and that death occurred at <u>6:15 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J.M.R. 1</u>		ADDRESS <u>Sandy Spring, Maryland</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3/23/56</u>	<u>Union-Burtonsville, Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-22-56</u>	<u>Gertrude B. Lawley</u>	<u>DeWitt Donaldson-Luxrel, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAR 28 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03110

3136

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>		d. STREET ADDRESS <b>1746 Q St., N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b> Middle <b>Ames</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>20 April 1873</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nathaniel Ames (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Mc Donald (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Thomas Sandoz, 2 DuPont Circle, Washington, D.C.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Left Ventricle</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Infarction</b> DUE TO (c) <b>Arteriosclerotic Coronary Artery Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hr</b> <b>5 hr</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 March</b> , 19 <b>56</b> , to <b>21 March</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>21 March</b> , 19 <b>56</b> , and that death occurred at <b>11:00 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard G. Fosburg</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md. 3-22-56</b>	
PHYSICIAN'S NAME (Type) <b>Richard G. Fosburg, LTJG, MC, USN</b>		U.S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>26 March 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. PUMPHREY</b>		ADDRESS <b>Bethesda, Md.</b> <b>7557 Wisconsin Ave.,</b>	
24a. REC'D BY REGISTRAR <b>3-21-56</b>		24b. REGISTRAR'S SIGNATURE <b>Mary E. Passelty</b>	



BUREAU

MAR 23 1956

RECEIVED

3137

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase 15, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hosp.</u>		d. STREET ADDRESS <u>9131 Jones Mill Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Bernhard</u> Middle <u>Winkler</u> Last		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 5, 1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Bernhard Winkler</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Son, Fred B. Winkler</u>		Address <u>8728 Suzanna Ln.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, terminal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriovascular sclerosis, bilateral</u> DUE TO (c) <u>Arterio sclerosis generalised</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>5 yrs.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary infarcts left Lung. Bronchopneumonia rt. lung</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1952</u> , to <u>March 22, 1956</u> , that I last saw the deceased alive on <u>3-21</u> , 19 <u>56</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stewart Clapp</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>3921 Ingomar Sp. W. W. DC. 3-22-56</u>	
PHYSICIAN'S NAME (Type) <u>Stewart Clapp MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>3-26-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>8-26-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Robert A. Humphrey-Bellows, Maryland

111-7000-100-2-3 1012105

1913

1956 28 MAR

BUREAU V. S.

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 223

3916

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Colorado</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grand Junction</u> 44x3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San &amp; Hospital</u>		d. STREET ADDRESS <u>943 Rood Ave Apt. 6.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>AMY CATHERINE WOLFE</u>		4. DATE OF DEATH Month Day Year <u>March 22 1956</u>	
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-78 1883</u>
9. AGE (In years last birthday) <u>82 1/2</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.S. Wk.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William H. Sheets</u>		14. MOTHER'S MAIDEN NAME <u>Anna M. Croff</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 14, 1956</u> to <u>Mar 22, 1956</u> , that I last saw the deceased alive on <u>Mar 22, 1956</u> , and that death occurred at <u>8:30 p.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond O. West</u> M.D.		ADDRESS (Street, city or town, state) <u>7600 Carver Ave., Takoma Park</u>	
PHYSICIAN'S NAME (Type) <u>Raymond O. West</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>MAR 28, 1956</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>James J. Kelly</u> ADDRESS <u>254 Carroll St N.W.</u>		24a. REC'D BY REGISTRAR DATE <u>3/26/56</u>	24b. REGISTRAR'S SIGNATURE <u>F. Wilson Wood</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3108

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BUREAU V. 3

MAR 27 1956

RECEIVED



3138

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

## 1. PLACE OF DEATH:

COUNTY Montgomery MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) Bethesda LENGTH OF STAY (in this place)  
 OR TOWN  
 HOSPITAL OR INSTITUTE OR STREET ADDRESS 5721 Grosvenor Lane  
Resnor Sanitarium

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE 47X3 COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town) District of Columbia  
 OR TOWN  
 STREET ADDRESS (If rural give location) 4405 Warren St. N.W.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

KathleenWood4. DATE (Month) (Day) (Year) OF DEATH: March 24 19565. SEX: F6. COLOR OR RACE: W.7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Single8. DATE OF BIRTH: May 3, 19189. AGE last birthday 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mln.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10B. KIND OF BUSINESS OR INDUSTRY: Gov't Worker11. BIRTHPLACE (State or foreign country): Decorah Iowa12. CITIZEN OF WHAT COUNTRY? U.S.13. FATHER'S NAME: Thomas B. Wood14. MOTHER'S MAIDEN NAME: Elizabeth Jane Self

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)

15. SOCIAL SECURITY NO.

17. INFORMANT & ADDRESS: Mrs. Sadie W. Porter. (Same)

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1

## IMMEDIATE CAUSE

(A) Respiratory Failure  
DUE TO

## ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Cardiovascular Decompensation  
DUE TO(C) Arteriosclerosis & myocardial degeneration 3 yrs.INTERVAL BETWEEN ONSET AND DEATH  
1 day  
6 months

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1954, to Mar. 24, 1956, that I last saw the deceased alive on 3/24, 1956, and that death occurred at 6:22 PM, from the causes and on the date stated above.SIGNATURE [Signature]ADDRESS 4301-46TH ST., N. W.DATE SIGNED 3/24/56M. D. WASHINGTON, D. C.23. BURIAL CREMATION, REMOVAL (SPECIFY) BURIALDATE THEREOF 3/27/56NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERYLOCATION (City, town, or county) PRINCE GEORGES MD.

(State)

DATE REC'D BY LOCAL REGISTRAR 3-27-56REGISTRAR'S SIGNATURE Bessie M. Thompson24. FUNERAL DIRECTOR S. H. HINES CO.ADDRESS 2901-14TH ST. N.W.WASHINGTON, D. C.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 29 1956

RECEIVED

3139

03114

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 214

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>montg</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Keensington</u>				TOWN <u>Keensington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3901 Hampton St.</u>				STREET ADDRESS (If rural, give location) <u>3901 Hampton St</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>Eva</u>		<u>Genevieve</u> <u>Woods</u>		<u>Mar</u> <u>15</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	10. PLACE - (State or foreign country):	11. CITIZEN OF WHAT COUNTRY?	
<u>Female</u>	<u>Caucasian</u>	<u>Married</u>	<u>Nov. 13, 1892</u>	<u>63</u> yrs.	<u>Virginia</u>	<u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:					
13. FATHER'S NAME: <u>Marshall Turner</u>				14. MOTHER'S MAIDEN NAME: <u>Belle Hangerfield</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Joseph Wood. 3901 Hampton St. Keensington, md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u>						<u>sudden</u>	
DUE TO							
Antecedent cause(s) (b) <u>Hypertension</u>						<u>3 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Frank J. Broschart</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-19-56</u>		NAME OF CEMETERY OR CREMATORY <u>St Johns</u>		LOCATION (City, town, or county) (State) <u>Forest Glen, md</u>	
DATE REC'D BY LOCAL REG. <u>3-19-56</u>		REGISTRAR'S SIGNATURE <u>Francis Peller</u>		24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		ADDRESS <u>Rockville, md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 21 1956

RECEIVED

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3140

## CERTIFICATE OF DEATH

Reg. Dist. No.

03115

277

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. LENGTH OF STAY IN 1b <u>25 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>73 Montgomery County General Hospital</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Brewer</u> Last <u>Worley</u>				4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>January 27, 1983</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Stock Room Employee</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>William Nevans Worley</u>				14. MOTHER'S MAIDEN NAME <u>Sue Magruder Waters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-22-1532</u>		17. INFORMANT <u>Hospital Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> <u>154 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Rectum</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>5 day</u> <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>2/18</u> , 19 <u>56</u> to <u>3/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3/19</u> , 19 <u>56</u> , and that death occurred at <u>6:50 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. W. Bird</u>				ADDRESS (Street, city or town, state) <u>Logansville 1094</u>			
PHYSICIAN'S NAME (Type) <u>J. W. Bird, M. D.</u>				DATE SIGNED <u>3-21-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 22 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LOUDEN PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 29</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Roy W Barber</u>				ADDRESS <u>Logansville 1094</u>		24a. REC'D BY REGISTRAR <u>DATE 3-21-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Gertrude B Lawler</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

<p>1. Name of deceased: <i>John Doe</i></p>		<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>		<p>4. Date of birth: <i>Jan 15, 1910</i></p>	
<p>5. Place of birth: <i>New York City</i></p>		<p>6. Date of death: <i>Mar 10, 1956</i></p>	
<p>7. Cause of death: <i>Heart Disease</i></p>		<p>8. Place of death: <i>Home</i></p>	
<p>9. Signature of physician: <i>[Signature]</i></p>		<p>10. Signature of registrar: <i>[Signature]</i></p>	
<p>11. Date of registration: <i>Mar 15, 1956</i></p>		<p>12. Office of registration: <i>Bureau V. 2</i></p>	

RECEIVED

MAR 28 1956

BUREAU V. 2

3141

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Montgomery</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		STATE <u>md</u> COUNTY <u>Montgomery</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Alta Vista Rest Home</u>		LENGTH OF STAY (in this place) <u>5 yrs 8 mo</u>		STREET ADDRESS (If rural give location) <u>9517 Old Georgetown Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Emma W Thright</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 14 1956</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct. 21, 1899</u>	
9. AGE last birthday <u>98</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cit Home</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>George Thilson</u>				14. MOTHER'S MAIDEN NAME: <u>Marion Plowman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mrs. Bessie Thright Bethesda, Md. 9700 Old Georgetown Rd.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u>						YEARS	
ANTECEDENT CAUSE (B) <u></u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u></u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN</u> , 19 <u>54</u> , to <u>MAR</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>MAR 14</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Dr. W. E. S. Sauter</u>		ADDRESS <u>M. D. 8025 ABERDEEN RD Bethesda Md.</u>		DATE SIGNED <u>3/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glenwood</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>8-15-56</u>		REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>		24. FUNERAL DIRECTOR <u>The S. T. Henric Co.</u>		ADDRESS <u>2901- Fourteenth St. Washington (9), D.C.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 19 1956

BUREAU V. S.

3142

## CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>7930 Georgetown Road</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>George</u> Last <u>Yendell</u>		4. DATE OF DEATH Month <u>March</u> Day <u>18</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-80</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Capital Transit</u>	
11. BIRTHPLACE (State or foreign country) <u>Devonshire, England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Yendell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Fisher</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Estelle Y. Cobbed</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage Massive Gastro-Intestinal</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma of Cecum</u> DUE TO (c) <u>Adeno Carcinoma Pancreas</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>8 hr</u> <u>3 Mo.</u> <u>9 Mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>18 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>18 March</u> , 19 <u>56</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1816 Ave. N.W. D.C.</u> DATE SIGNED <u></u>			
ACTUAL SIGNATURE <u>John G. Ball</u>		M.D. <u>7936 Georgetown Rd. Bethesda Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		<u>7936 Georgetown Rd. Bethesda Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-Transit</u>		22b. DATE THEREOF <u>3/20/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Union Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Westchester Co. Rye N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>DATE 3-19-56</u>		24b. REGISTRAR'S SIGNATURE <u>Bessie M. Thompson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3017

## CERTIFICATE OF DEATH

Reg. Dist. No.

03118

223

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>17 TAKOMA PARK</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING 56</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>75 WASHINGTON SA. &amp; HOSPITAL</b>		d. STREET ADDRESS <b>GEORGIA AVE. AT D. C. LINE 1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>ALBERT</b> Last <b>YOST, SR.</b>		4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> (NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 5, 1883</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN (RETIRED)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD. NAT'L. CAP. PK. &amp; PLANNING COMM.</b>	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD YOST</b>		14. MOTHER'S MAIDEN NAME <b>JODY BELT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>MR. EDWARD E. YOST, 10,604 HUNTLEY PL.</b>		Address <b>SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Uremia</b> DUE TO <b>Arteriosclerosis Generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>8-10 yrs.</b> (c) <b>8-10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post Surgical Transurethral Resection of Prostate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Dec., 1955</b> , to <b>23 March, 1956</b> , that I last saw the deceased alive on <b>22 March, 1956</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. B. Queen</b>		ADDRESS (Street, city or town, state) <b>7112 Willow Ave. M.D. Takoma Park, Md.</b>	
PHYSICIAN'S NAME (Type) <b>M. B. QUEEN</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/26/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner &amp; Humphrey</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>3/16/56</b>		24b. REGISTRAR'S SIGNATURE <b>Wilson Dodd</b>	

BUREAU V. 3

MAR 27 1956

RECEIVED